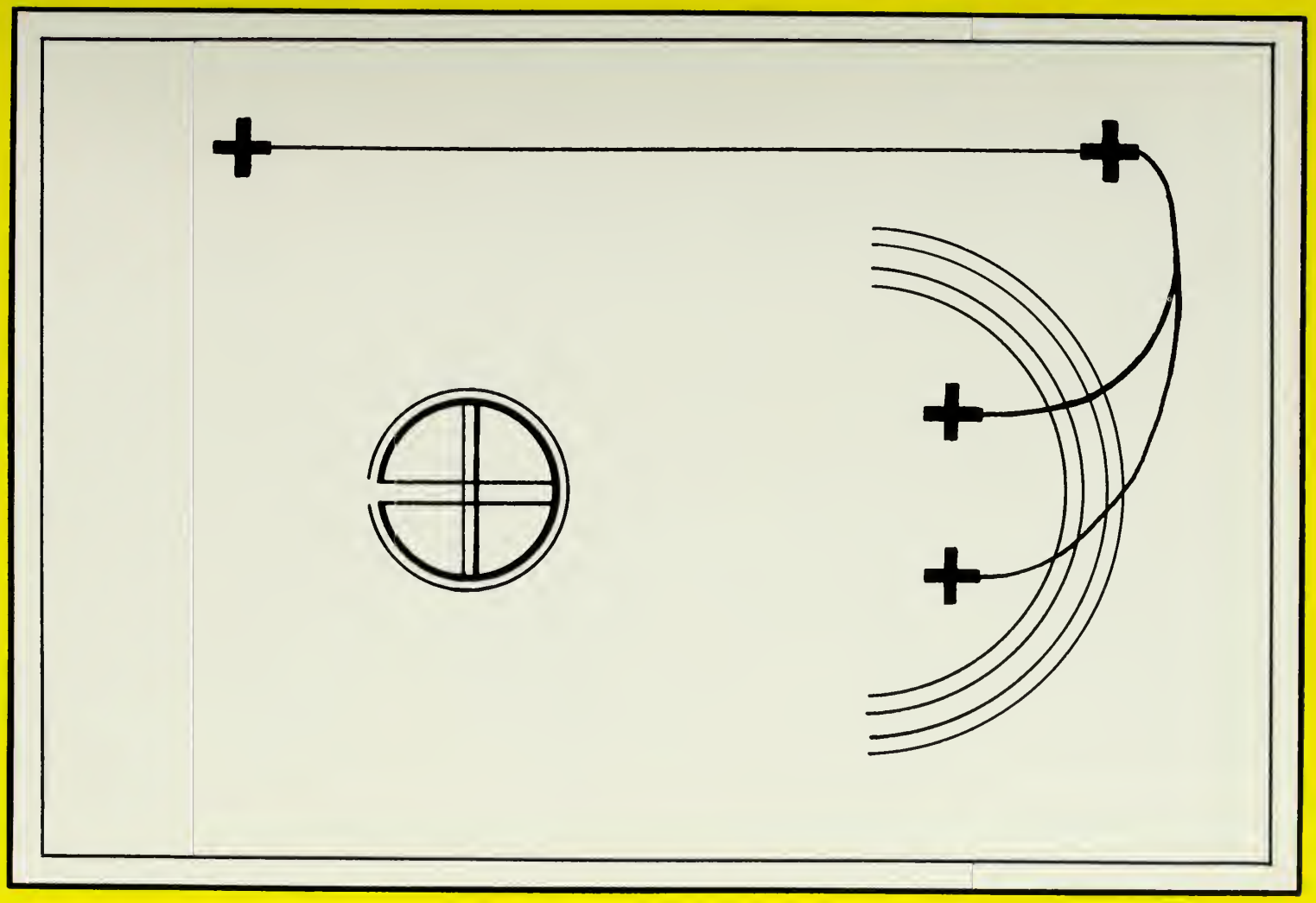
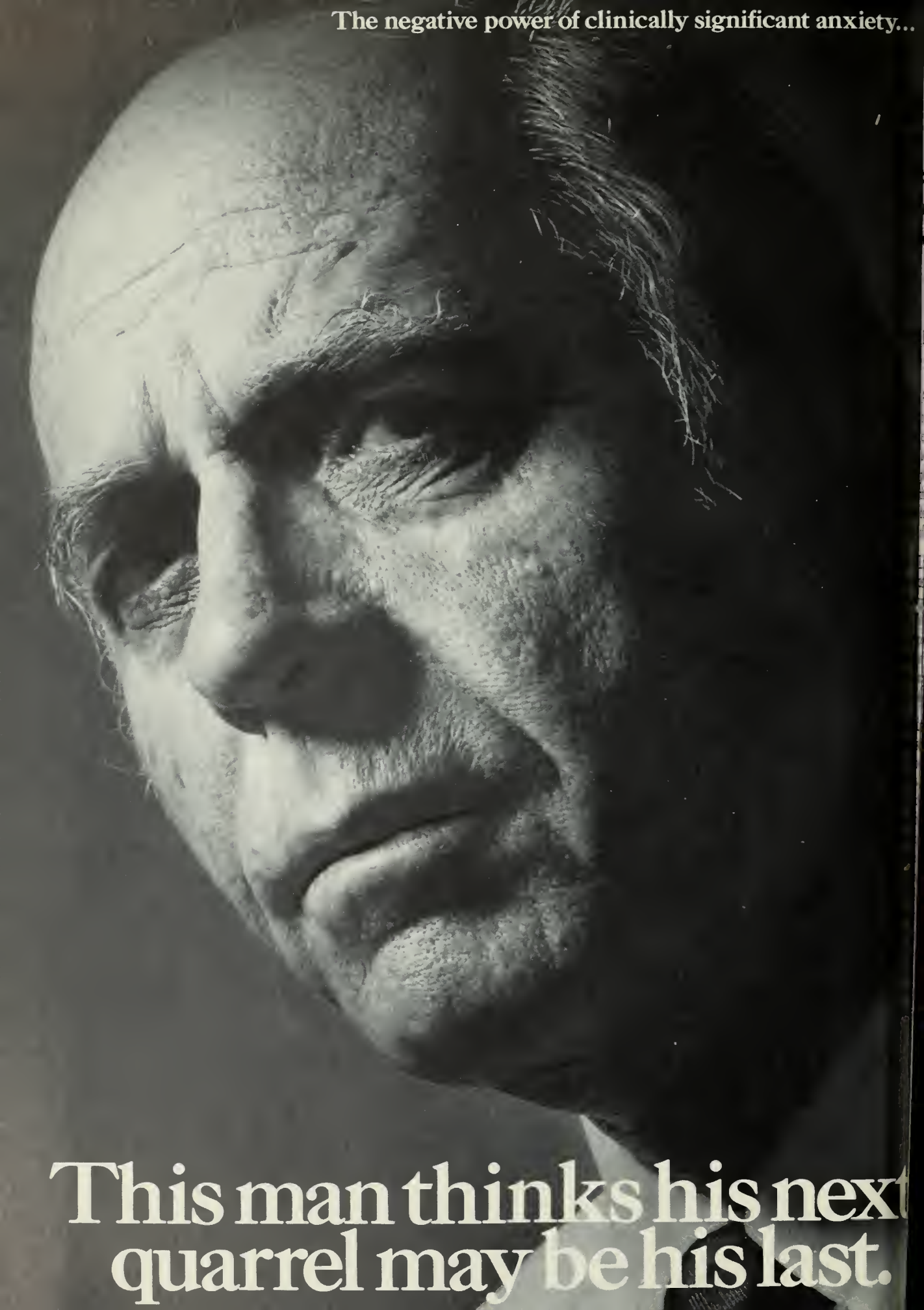


HARVARD MEDICAL ALUMNI BULLETIN

Jan. / Feb. 1972

The negative power of clinically significant anxiety...



This man thinks his next quarrel may be his last.

For the hypertensive patient, severe symptoms may be intensified and aggravated by emotional overreaction to stress. Acutely aware of the adverse impact his emotions may have on the course of his life, the hypertensive patient's anxieties may be increased.

Adjunctive use of Libritabs may be of significant value in reducing excessive anxiety, which can induce adverse biochemical and physiological changes related to the vascular system and, by so doing, jeopardize management of the disease itself.

Libritabs (chlordiazepoxide) is used concomitantly with certain specific medications of other classes of drugs, such as cardiac glycosides, diuretics and antihypertensive agents, whenever anxiety is a significant component of the clinical profile.

Libritabs is especially well suited for extended use because of its wide margin of safety. In general use, the most common side effects reported have been drowsiness, ataxia and confusion, particularly in the elderly and debilitated. (See summary of prescribing information.) Moreover, the antianxiety benefits of Libritabs are generally maintained without diminution of effect or need for increase in dosage. When treatment is prolonged, periodic blood counts and liver function tests are advisable.

Libritabs (chlordiazepoxide) permits flexible, individualized therapy through its three oral dosage strengths.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances, syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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Libritabs®

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5-mg, 10-mg, 25-mg tablets

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The tour program covers areas where those who might otherwise prefer to travel independently will find it advantageous to travel with a group. The itineraries have been carefully constructed to combine the freedom of individual travel with the convenience and savings of group travel. There is an avoidance of regimentation and an emphasis on leisure time, while a comprehensive program of sightseeing ensures a visit to all major points of interest. Hotel reservations are made as much as a year and a half in advance to ensure the finest in accommodations.

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A luxury "safari" to the great national parks and game reserves of Uganda, Kenya and Tanzania. The carefully planned itinerary offers an exciting combination of East Africa's spectacular wildlife and breathtaking natural scenery: great herds of elephant and a launch trip through hippo and crocodile in **MURCHISON FALLS NATIONAL PARK**; multitudes of lion and other plains game in the famed **SERENGETI PLAINS** and the **MASAI-MARA RESERVE**; the spectacular concentration of wildlife in the **NGORONGORO CRATER**; tree-climbing lions around the shores of **LAKE MANYARA**; the **AMBOSELI RESERVE**, where big game can be photographed against the towering backdrop of snow-clad Mt. Kilimanjaro; and the majestic wilds of **TSAVO PARK**, famed for its elephant and lion as well as its unusual Mzima Springs. Also included are a cruise on **LAKE VICTORIA** in Uganda and visits to the fascinating capital cities of **KAMPALA** and **NAIROBI**. The altitude in East Africa provides an unusually stimulating climate, with bright days and crisp evenings (frequently around a crackling log fire), and the tour follows a realistic pace which ensures a full appreciation of the attractions visited. Total cost is $1699 from New York. Optional extensions are available to the famed **VICTORIA FALLS**, on the mighty Zambezi River between Zambia and Rhodesia, and to the historical attractions of **ETHIOPIA**. Departures in January, February, March, May, June, July, August, September, October, November and December 1972 ($25 additional for departures in June, July, August).

THE ORIENT

30 DAYS $1759

1972 marks the eighth consecutive year of operation for this outstanding tour, which offers the greatest attractions of the Orient at a sensible and realistic pace. Twelve days are devoted to the beauty of **JAPAN**, visiting the ancient "classical" city of **KYOTO**, the modern capital of **TOKYO**, and the lovely **FUJI-HAKONE NATIONAL PARK**, with excursions to ancient **NARA**, the magnificent medieval shrine at **NIKKO**, and the giant Daibutsu at **KAMAKURA**. Visits are also made to **BANGKOK**, with its glittering temples and palaces; the fabled island of **BALI**, considered one of the most beautiful spots on earth; the ancient temples near **JOGJAKARTA** in central Java; the mountain-circled port of **HONG KONG**, with its free port shopping; and the cosmopolitan metropolis of **SINGAPORE**, known as the "cross-roads of the East." Tour dates include outstanding seasonal attractions in Japan, such as the spring cherry blossoms, the beautiful autumn leaves, and some of the greatest annual festivals in the Far East. Total cost is **$1759** from California, **$1965** from Chicago, and **$2034** from New York, with special rates from other cities. Departures in March, April, June, July, September and October 1972.

AEGEAN ADVENTURE

22 DAYS $1329

This original itinerary explores in depth the magnificent scenic, cultural and historic attractions of Greece, the Aegean, and Asia Minor—not only the major cities but also the less accessible sites of ancient cities which have figured so prominently in the history of western civilization, complemented by a luxurious cruise to the beautiful islands of the Aegean Sea. Rarely has such an exciting collection of names and places been assembled in a single itinerary—the classical city of **ATHENS**; the Byzantine and Ottoman splendor of **ISTANBUL**; the site of the oracle at **DELPHI**; the sanctuary and stadium at **OLYMPIA**, where the Olympic Games were first begun; the palace of Agamemnon at **MYCENAE**; the ruins of ancient **TROY**; the citadel of **PERGAMUM**; the marble city of **EPHESUS**; the ruins of **SARDIS** in Lydia, where the royal mint of the wealthy Croesus has recently been unearthed; as well as **CORINTH, EPIDAUROS, IZMIR** (Smyrna) the **BOSPORUS** and **DARDENELLES**. The cruise through the beautiful waters of the Aegean will visit such famous islands as **CRETE** with the Palace of Knossos; **RHODES**, noted for its great Crusader castles; the windmills of picturesque **MYKONOS**; the sacred island of **DELOS**; and the charming islands of **PATMOS** and **HYDRA**. Total cost is **$1329** from New York. Departures in April, May, July, August, September and October, 1972.

MOGHUL ADVENTURE

29 DAYS $1725

An unusual opportunity to view the outstanding attractions of India and the splendors of ancient Persia, together with the once-forbidden mountain kingdom of Nepal. Here is truly an exciting adventure: India's ancient mounuments in **DELHI**; the fabled beauty of **KASHMIR** amid the snow-clad Himalayas; the holy city of **BANARAS** on the sacred River Ganges; the exotic temples of **KHAJURAHO**; renowned **AGRA**, with the Taj Mahal and other celebrated monuments of the Moghul period such as the Agra Fort and the fabulous deserted city of Fatehpur Sikri; the walled "pink city" of **JAIPUR**, with an elephant ride at the Amber Fort; the unique and beautiful "lake city" of **UDAIPUR**; a thrilling flight into the Himalayas to **KATHMANDU**, capital of **NEPAL**, where ancient palaces and temples abound in a land still relatively untouched by modern civilization. In **PERSIA** (Iran), the visit will include the great 5th century B.C. capital of Darius and Xerxes at **PERSEPOLIS**; the fabled Persian Renaissance city of **ISFAHAN**, with its palaces, gardens, bazaar and famous tiled mosques; and the modern capital of **TEHERAN**. Outstanding accommodations include hotels that once were palaces of Maharajas. Total cost is **$1725** from New York. Departures in January, February, August, October and November 1972.

Rates include Jet Air, Deluxe Hotels, Most Meals, Sightseeing, Transfers, Tips and Taxes. Individual brochures on each tour are available.

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HARVARD MEDICAL ALUMNI BULLETIN
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A SPECIAL ISSUE ON THE AMERICAN INDIAN

Cover: An artistic rendition of a Navajo sand painting used in a ceremony to impart health to young Indian warriors. The ceremony is based on the ancient legend, "Where the Two Came to Their Father."*

Editor's Note: With this issue, the *Bulletin* discontinues its Along the Perimeter pages and introduces an expanded news section called Overview. It is our intention to present current School and hospital news, but because of our bi-monthly publication schedule, we must occasionally ask the reader's indulgence.

Credits: Cover and all Indian drawings by Juliann Heye; Drawings by Bruce Reider '75, p. 5, 7; Fabian Bachrach, p. 8; George Cushing, Jr., p. 9; Courtesy of Peabody Museum, pp. 17-19, 28, 32, 35-37; Bradford F. Herzog and Kenneth M. Prager, pp. 21-25; Karl L. Singer, p. 27.

* "Where the Two Came to Their Father" by Maud Oakes. Published by Princeton University Press, 1969.

OVERVIEW

Braunwald Named to Hersey Chair

The tenth incumbent of one of Harvard's most prestigious chairs will be Eugene Braunwald, M.D., professor and chairman of the department of medicine at the University of California, San Diego, School of Medicine.

On July 1, 1972, Dr. Braunwald will succeed George W. Thorn, M.D., as the Hersey Professor of the Theory and Practice of Physic at Harvard and physician-in-chief at the Peter Bent Brigham Hospital where he will also head Harvard's department of medicine.

Recognized as one of the foremost cardiologists in the U.S., Dr. Braunwald was among the first to document pressure gradients across the heart valves in disease, and to document quantitatively the extent of repair that could be achieved surgically. In 1959 he defined a new form of aortic stenosis and the following year, described the syndrome of idiopathic hypertrophic subaortic stenosis, an entity which accounted for many cases of apparent outflow obstruction from the left ventricle, in which the aortic valve itself was normal.

Of continuing interest to Dr. Braunwald has been the action of the cardiac glycosides, and he has clarified their mode of action in man, together with the biochemical and pharmacological determinants of that action. In conjunction with these studies, he has documented the role of the autonomic nervous system in controlling cardiac function in both the normal and pathologic heart.

More recently, his chief interests have been the diseases of the coronary arteries and the pharmacologic control of the coronary vascular bed.

Dr. Braunwald received the M.D. degree in 1952 from New York University. For ten years he served the National Institute of Health as chief, section of cardiology, clinic of surgery (1958-60); chief, cardiology branch (1960-68); and clinical director (1966-68). In 1968 he assumed his post at San Diego where he was also chief of medicine at University Hospital of San Diego County.

Among his numerous honors are: Arthur S. Flemming Award for Outstanding Service in the Federal Government, 1965; John Jacob Abel Award for Research in Pharmacology from the American Society for Pharmacology and Experimental Therapeutics, 1965; Superior Service Award from the U.S. Department of Health, Education, and Welfare, 1967; Distinguished Achievement Award from *Modern Medicine*, 1968; Gustav Nylin Award from the Swedish Medical Society, 1970; and the Einthoven Medal from the Dutch Cardiac Society, 1970.

Dr. Braunwald

The Hersey Professorship of the Theory and Practice of Physic was the first endowed professorship in the Harvard Medical School. The Professorship was established through a bequest of 1000 English pounds from Dr. Ezekiel Hersey, a physician in Hingham, Massachusetts. His portrait, which for many years hung in the Faculty Room at Harvard, now hangs in the main foyer of the Francis A. Countway Library of Medicine.

The first incumbent of the Hersey Professorship was Dr. Benjamin Waterhouse who was succeeded by Dr. James Jackson in 1812. The occupants of the Chair over the years have been: Dr. John Ware, 1836-1858; Dr. George Shattuck, 1859-1874; Dr. Francis Minot, 1874-1891; Dr. Reginald Fitz, 1892-1908; Dr. Henry Christian, 1908-1939; Dr. Soma Weiss, 1939-1942; and Dr. George Thorn, 1942-1972.

Mankin Appointed Ashley Professor

Henry J. Mankin, M.D., will become the Edith M. Ashley Professor of Orthopedic Surgery at Harvard Medical School on July 1, 1972. Simultaneously, he will become orthopedist-in-chief at Massachusetts General Hospital. Dr. Mankin comes to Harvard from Mt. Sinai School of Medicine where he is professor and chairman of the department of orthopedics. He is also director of orthopaedics at the Hospital for Joint Diseases.

Regarded by his peers as an outstanding educator and scientist, he has made significant contributions in both areas. His activities on behalf of the American Academy of Orthopedic Surgeons have put the AAOS at the forefront of postgraduate specialty education. Dr. Mankin developed and administered an in-training examination that is a model of innovative adult education.

As a scientist, he has concentrated on a particularly difficult area of research — articular cartilage, the connective tissue covering the surfaces of bones forming a joint. He has elucidated most of the knowledge of how articular chondrocytes replicate during growth in adolescence, and how they respond to injury, aging, and steroids.

Dr. Mankin received the M.D. degree in 1953 from the University of Pittsburgh. He is an associate editor of *Arthritis and Rheumatism*, the *Journal of Bone and Joint Surgery*, and the *American Digest of Foreign Orthopaedic Literature*. He is also one of two orthopedic representatives at the National Institutes of Health.

The Ashley Chair was established by Harvard University in 1961 with a gift of capital from the Edith M. Ashley Fund of the Permanent Charity Fund, Inc., of Boston. Under the terms of the gift, the initial holder of the Chair was to be in the field of orthopedic surgery and based at the Massachusetts General Hospital. The first incumbent was Melvin J. Glimcher '50 who is now the Harriet M. Peabody Professor of Orthopedic Surgery at HMS and orthopedist-in-chief at Children's Hospital Medical Center.

Dr. Mankin

Biggers Becomes Professor of Physiology

A leading authority on ovum development in mammals, John D. Biggers, Ph.D., D.Sc., has been appointed professor of physiology at HMS.

As a reproductive biologist, Dr. Biggers' more recent research has dealt with the pre-implantation stages of development. He pioneered in developing methods for the study of oogenesis, particularly the environmental requirements for the growth and development of the fertilized egg and blastocyst within the mother's reproductive organs.

British born and educated, Dr. Biggers comes to Harvard from Johns Hopkins University School of Hygiene and Public Health where he was professor of population dynamics. He received the Ph.D. in physiology in 1952, and the D.Sc. degree in 1965 from the University of London.

He was a founder member and a former president (1969) of the Society for the Study of Reproduction and is presently the editor of their journal, *Biology of Reproduction*. Since 1968, he has served as associate editor of the *Journal of Experimental Zoology*. He is a member of the NIH Study Section on Reproductive Biology, a consultant to the WHO and the NICHD Population Center, and a member of a UNESCO International Committee on Reproductive Biology.

Dr. Biggers is a member of the Royal Statistical Society, the International Biometrics Society, the American Statistical Society, and Sigma Xi.

Anderson Named Anatomy Professor

Everett Anderson, Ph.D., has been appointed professor of anatomy and member of the Laboratory of Human Reproduction and Reproductive Biology at HMS. Dr. Anderson is an authority in the field of oogenesis and utilizes both light and electron microscopes in his investigations. One of the experts in the cytological aspects of reproductive biology in mammalian as well as non-mammalian females, Dr. Anderson is considered to be a lucid and stimulating teacher by both his students and associates.

Dr. Anderson received his B.A. and M.A. degrees in zoology from Fisk University and the Ph.D. degree from State University of Iowa, also in zoology.

Prior to his appointment at Harvard, Dr. Anderson was a professor of zoology at the University of Massachusetts in Amherst, assistant professor of zoology at the State University of Iowa, and instructor in anatomy at Howard University School of Medicine.

Dr. Anderson is an associate editor of the *Anatomical Record*, *Journal of Experimental Zoology*, *Journal of Morphology*, and is on the editorial board of *Biology of Reproduction*.

He is a member of the Corporation and consultant in the embryology course at the Marine Biological Laboratory, Woods Hole; and a member of the evaluating panel, National Academy of Science for NATO Postdoctoral Fellowships in Science. He serves as curriculum consultant to the American Institute of Biological Sciences, AIBS Consultant Bureau, and is a member of the Population Research and Training Committee of the Population and Reproduction Grants Branch, Center for Population Research, National Institute of Child Health and Development.

DuVal Clarifies Nixon's Health Policy

The second lecture in the "Medicine in Society" series was delivered by Merlin K. DuVal, Assistant Secretary for Health and Scientific Affairs in the Department of Health, Education, and Welfare.

Speaking to a surprisingly small audience, composed mostly of faculty members, Dr. DuVal discussed, "Health Policies in the Nixon Administration."

Dr. DuVal began by defining the pending crisis in health care, which is basically a conflict between consumer and provider.

Briefly, the consumer, or patient, views health care as a right, and believes he should have a voice in the manner of delivery of this care. The providers, or medical profession, on the other hand, constitute, in effect, a virtually self-governing monopoly. The profession obeys none of the rules of the economic marketplace; the consumer has no means to control or influence this monolithic giant.

In this current confrontation, the government will act as a catalyst and, according to Dr. DuVal, will enter the fray on three major fronts.

First, in the area of financing health care, particularly with reference to insurance. There have been some 25 national health insurance proposals introduced into the legislature during the past few years and these run the gamut from the Broyhill bill to the Kennedy-Griffiths bill. Dr. DuVal expects that some type of *via media* bill, whereby there would be mandated coverage by employers for employees, will be accepted by Congress late in 1973.

Second, the production of manpower. The federal government has taken a significant step in this area by classifying academic medical centers as national resources for the first time. Prior to this, they were considered local or regional resources. DuVal said that government would invest heavily in new types of manpower, with particular focus on primary and first contact physicians. Major funding will also be available for physician extenders and such other types of manpower as will increase the ability of the physician to more efficiently meet existing health needs.

Dr. DuVal

Finally, the government will encourage institutional reform. In essence, this would mean a substantial change in the distribution of health services — increased physician efficiency, more group practice and pre-paid group practice, and a greater use of technology.

During the question and answer period that followed the lecture, Dr. DuVal was asked to elucidate the administration's specific philosophy on health. Without hedging, he stated it as follows:

> It is better to build on existing strengths than to "throw out the baby with the bathwater."
>
> Federal money should be used to achieve institutional reform rather than create new and duplicative instruments.
>
> Money should be spent now to avoid later dependence on government.

Finland's Generosity Creates I.D. Fund

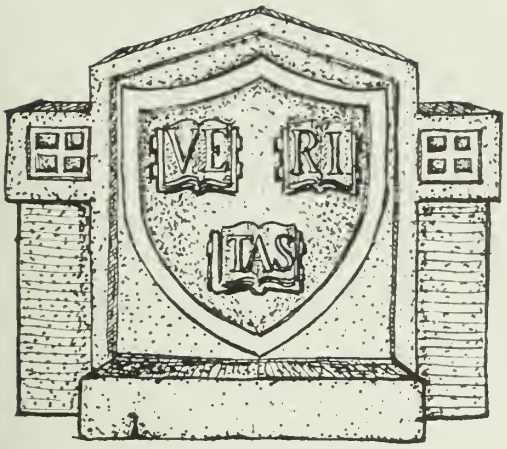
A personal gift of $10,000 from Maxwell Finland '26, George Richards Minot Professor of Medicine, Emeritus, has established a Fund for Infectious Diseases in the Medical School's department of medicine at Boston City Hospital. Additional gifts have already increased the Fund to a total of $100,000. Income from the fund, when activated, will be used to support a fellowship in infectious diseases at the hospital.

The original gift is the cash prize Dr. Finland received when the AMA presented him with the Fourth Annual Dr. Rodman E. Sheen and Thomas G. Sheen Award, in June, 1971. He was cited by the president of the AMA for his "exceptional contributions to medical science through definitive studies on nearly every antibiotic introduced in the past three decades . . . and for his equally significant role in educating those now constituting the world's nucleus of experts in infectious diseases."

Dr. Finland's wish to perpetuate the role of young fellows and students as future teachers and scientists led him to contribute his prize which started the fund. He hopes that additional gifts from other sources will be added to this capital fund until it reaches a minimum of $250,000, the income from which will be used for the fellowship.

Robert H. Ebert commended Dr. Finland for his "continued demonstration of loyalty and concern for strengthening the financial resources of the Medical School."

Dr. Finland's career culminated in 1968 when he retired as director of the Harvard Medical Unit at BCH and became George Richards Minot Professor of Medicine, Emeritus. He continues his activities as head of the division of epidemiology in the laboratory of infectious diseases at BCH, and president of the Harvard Medical Alumni Association.



PROMOTIONS AND APPOINTMENTS

ASSOCIATE PROFESSOR

Raquel E. Cohen '49: psychiatry at Massachusetts Mental Health Center (MMHC)
Dieter Koch-Weser: preventive and social medicine at HMS
Roger E. Meyer '62: psychiatry at Boston City Hospital (BCH)
A. Michael Rossi: psychology in the department of psychiatry
Donald J. Scherl '61: psychiatry at MMHC
Emil R. Unanue: pathology

ASSOCIATE CLINICAL PROFESSOR

Richard A. Bloomfield '38: medicine

ASSISTANT PROFESSOR

Frank Baker: psychology in the department of psychiatry
George E. Battit: anesthesia at Massachusetts General Hospital (MGH)
Harold R. Behrman: physiology
George J. Busch: pathology at Peter Bent Brigham Hospital (PBBH)
William D. Clark '65: medicine at Cambridge Hospital (CH)
Laurence H. Cohn: surgery at PBBH
Stanley B. Eaton '64: radiology at MGH
Loren H. Hartley: medicine
Ralph G. Hirschowitz: psychiatry at MMHC
David H. Katz: pathology
Michael D. Klein: medicine at PBBH
Bernard D. Kosowsky '62: medicine at PBBH
Samuel A. Latt '64: pediatrics
Paul D. Leber: pathology at The Children's Hospital (TCH)
John D. MacArthur: surgery at PBBH
Albert R. Martin '63: medicine at CH
Jay P. Mohr: neurology at MGH
Theodore Nadelson: psychiatry at Beth Israel Hospital (BIH)
Herbert L. Needleman: psychiatry at MMHC
Majic S. Potsaid: radiology at MGH
Stanley J. Reiser: history of medicine in the Faculty of Medicine
Noel I. Robin: medicine at CH
Bhagwan T. Shahani: neurology at MGH
Stephen M. Shea: pathology at MGH
Samuel Stern: physiology
Laurence A. Stone: psychiatry at McLean Hospital (McLH)
Richard N. Wolman: psychology in the department of psychiatry at CH
Edward R. Wolpow '64: neurology at MGH

ASSISTANT CLINICAL PROFESSOR

Ralph P. Engle, Jr. '57: psychiatry
Milton Hodosh: oral pathology
Don R. Lipsitt: psychiatry
John T. Maltsberger 3d '59: psychiatry
Norman L. Paul: psychiatry
Joseph Pines: medicine
Stefan C. Schatzki '56: radiology
Lionel A. Schwartz: psychiatry
Benjamin Shambaugh '47: psychiatry
Richard J. Simmons '57: ophthalmology
Alan R. Spievack '59: surgery

PRINCIPAL ASSOCIATE

Jennie M. Smoly: neurology (biochemistry)

PRINCIPAL RESEARCH ASSOCIATE

Hari G. Garg: biological chemistry

LECTURER

David P. Lauler: medicine

Anonymous Gift of $1M Honors Alumnus

An anonymous donor's gift of one million in common stock has established the Theodore Bevier Bayles Professorship at Harvard Medical School.

The Professorship honors Dr. Bayles, a 1936 graduate of HMS, who is a recognized authority on arthritis and other joint diseases. Dr. Bayles is associate clinical professor of medicine at Harvard, and visiting physician at the Robert Breck Brigham Hospital.

The incumbent of the Bayles Professorship will serve at the RBBH. The donor has expressed the wish that the holder of the Chair will, insofar as is practicable, devote himself to furthering the study and treatment of arthritis, rheumatism, and related diseases.

Dr. Bayles began his association with the RBBH in 1939 when he was appointed a research fellow. From 1951 to 1966 he was director of research at the Hospital. He is a former president of the New England Rheumatism Society, and former second vice president of the American Rheumatism Association.

Dr. Bayles

Management and Health Collaborate

Responding to many requests for help in the training of men and women to administer health systems, the Faculty of the Harvard Business School has established a new Program for Health Systems Management. The Program, headed by Alan Sheldon, M.D., will be a collaborative effort on the part of the HBS, Medical School, School of Public Health, and Center for Community Health. This is the first major venture that involves these Harvard institutions.

The major purpose of the Program will be to teach modern management skills, concepts, and techniques to about 100 participants; an added function will be to examine the complexity of the system to which all health institutions belong. The secondary goal is to legitimize the role of management and management training in these areas.

Participants will be sought from three major health areas: regulatory, planning, and service-providing organizations of the federal and state governments; nongovernmental health services, such as community, private, and corporate health programs; and educational institutions. Other health areas will be included, among them, third party payers, profit oriented organizations such as laboratories, labor unions, and professional associations.

The Program will be an intensive course, offered yearly, on a full work week schedule. The curriculum is constructed to serve two purposes. It aims to give an adequate grounding in modern management and will offer the opportunity to explore, from a management point of view, many of the major health problems and issues of the present and future. These issues will be incorporated in two types of courses: management and health issues. Members of the faculties of the major Harvard institutions will share in the teaching, and it is hoped that this will facilitate an exploration of the interdependence of decision making within the various segments of the health system.

The above is excerpted from an article in the *Harvard Business School Bulletin*, Sept/Oct, 1971.

HCSP Seeks Funds

Approximately 50 minority students will be eligible to return to Harvard next summer for the fourth and possibly final session of the Health Careers Summer Program (HCSP), the largest and most successful program of its type in the nation.

Whether new registrants can be added to HCSP depends on the success of funding efforts now being undertaken. Registrants in the initial three years of the program, designed to strengthen the students' academic abilities in the basic sciences, have totalled 267.

Robert Blacklow '59, assistant to the dean of the Faculty and former director of the HCSP states that the program has received a total of $515,000 from eight national foundations and organizations. In addition to this, funds from the federal government and institutions in which the students are registered will be sought.

Thomas E. Crooks, director of the Harvard Summer School, who has taken over the directorship of HCSP, says that he is hopeful the program will be continued with new sources of financial support. The new director of the program pointed out that a substantial number of those who have been enrolled in the HCSP—Blacks, Puerto Ricans, American Indians, and Mexican Americans—have gone on to medical or dental school, or plan to enter one of the allied health professions.

Financial support has been provided by the Weir Foundation, National Fund for Medical Education, Sloan Foundation, Macy Foundation, Rockefeller Foundation, and the National Urban Coalition.

Pathophysiologist Presents Ellis Lecture

The seventh Laurence B. Ellis Lecture was delivered recently at the Harvard Medical Unit of Boston City Hospital by Dr. H.J.C. Swan, director of the department of cardiology at Cedars-Sinai Medical Center in Los Angeles.

Dr. Swan, an authority on the pathophysiology of atrial and ventricular septal defects and pulmonary hypertension, opened his lecture with an overview of unanswered questions concerning ischemic heart disease. He drew attention to the neglected effects of ischemia on the physical characteristics of the left ventricle and gave an elegant analysis of the potential effects of increased distensibility and increased stiffness on cardiac function. He concluded by analyzing clinical and bedside hemodynamic data obtained in patients with acute myocardial infarction and related these to prognosis.

The Lecture was established by the students, associates, and friends of Laurence B. Ellis '26, as a tribute to his contributions to cardio-vascular medicine.

Noted Pediatrician Wins First Hood Award

One of Harvard's most distinguished faculty members, Charles A. Janeway, M.D., has received the first Charles Hood Foundation Award of $250,000. He was chosen by a committee of prominent pediatric leaders as the individual who recently has made the greatest contribution to the health of New England children. Dr. Janeway is Thomas Morgan Rotch Professor of Pediatrics at HMS and Physician-in-Chief at The Children's Hospital Medical Center.

As recipient of the Hood Award, he was given the privilege of designating the use of the $250,000 for one or more projects in the area of child care. The projects will bear his name. Dr. Janeway has directed that the major portion of the award be used to provide the new equipment and facilities needed to strengthen the pediatric research program at Children's and the department of pediatrics. A smaller portion will support the development of an improved continuing education program for physicians and other child health workers in the New England area. The Hood Award also carried a personal honorarium.

Dr. Janeway received the M.D. degree from Johns Hopkins University in 1930. In 1937 he joined the staff of Harvard Medical School as research fellow in bacteriology and immunology. Promoted to Faculty rank in 1941, he became the Rotch Professor in 1946.

Since that time, he has played a vital role in educating large numbers of health professionals to provide child health care and services. Dr. Janeway's research has been concentrated in the area of infectious disease and the study of plasma protein metabolism.

Dr. Janeway

Macy Foundation Continues to Support History of Medicine

The Josiah Macy Jr. Foundation of New York has awarded $100,000 to the Program in the History of Medicine. The award was announced by Dr. John Z. Bowers, president of the Foundation. The Macy Foundation is primarily interested in medical education and has been influential in supporting and encouraging the study of the history of medicine and the biological sciences.

The History of Medicine Program began in 1966 with a grant of $60,000 from the Macy Foundation. Since then the Foundation has contributed a total of $220,000.

Directed initially by Hermann L. Blumgart '21, professor of medicine, emeritus, the director of the Program now is Stanley J. Reiser, M.D.

The History of Medicine Program is based upon several premises. The history of medicine provides a framework for understanding the nature of civilization's efforts to control disease and promote health, and accordingly, is an important branch of university scholarship. The analysis of medicine's past illuminates the forces that have produced its present structure and those that may influence its future. A knowledge of historical forces clarifies many aspects of clinical, scientific, and social medicine and can be significant for physicians who are attempting to solve the problems they encounter in professional life. Finally, the history of medicine provides a framework within which other academic disciplines may come together in a joint analysis of medical issues. Dr. Reiser notes that the Harvard program has sought to examine these connections through active teaching in many areas of academic interest.

Modern Eskimo

The Hidden Americans

by Vine Deloria, Jr.

Mr. Deloria is a member of the Standing Rock Sioux Tribe, Executive Director, Southwest Intergroup Council, and author of *Custer Died for Your Sins* and *We Talk, You Listen.*

AFTER nearly a century of obscurity the American Indian has raised his voice and declared his emotional and intellectual freedom from the bonds of western European culture. Whether, in the next decade, he will be able to achieve political and economic freedom is a question now emerging on a number of different fronts.

Recent tendencies of the New Left have defined all non-White groups as composing a "Third World" movement in which all non-White peoples share certain effects of colonialism and seek certain goals of self-determination. Based in part on the emergence of new nations and the withdrawal of European countries from their colonies after the last war, this ideology seeks to build a united political and conceptual alliance within the oppressed minorities of the nation.

The Third World rhetoric holds great fascination for many who have not yet pondered the variety of political change that has been shaping global conceptions of international law and morality for the past decade. But casually attaching American Indians to what is essentially a struggle centered in Africa and Asia, is to misjudge the historical experiences of the age of colonial conquest and the finality of what has happened in the industrialization of the world via western technology.

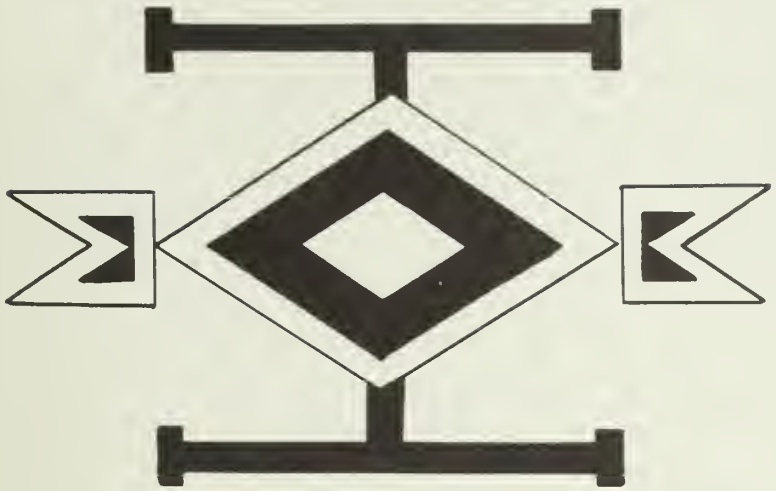
Instead, therefore, of gauging domestic problems primarily by international criteria, one must look more closely at the historical experiences of the American Indian which stand uniquely in the history of the continent, but which relate to a yet unconsidered category of people scattered throughout the world — the aboriginal peoples of the globe.

The necessary distinction to be made between the Third World and the Aboriginal World is at present political but will eventually be seen as religious and economic. The Third World is emerging at this time primarily because it is rapidly learning to adapt its life-style to western technology, it reacts to western political concepts, and it uses racial issues to pivot its expanding influence between the super-powers gathering concessions from both sides while struggling to imitate them.

The Aboriginal World lacks the political muscle to emerge, it basically rejects western political techniques, is unable to comprehend western technology, and finds its basic strength in ideology above and beyond western ideas of historical process. While the Third World can eventually emerge as a force capable of maintaining its freedom in the struggle between east and west, the Aboriginal World is almost wholly dependent upon the good faith and morality of the nations of east and west within which it finds itself.

One glance at the Aboriginal World illuminates its condition. In it are the Canadian, American, Mexican, and Central and South American Indians, the Lapps of northern Scandanavia, the Polynesian and Pacific basin peoples, the Basques of Spain, Welsh and Celts of Great Britain, the Maori and Australian aborigines. Perhaps one could project backwards in time and discover the Gypsies also belong in this category. And within the Soviet Union and China are numerous peoples unknown in the western world who share the status and perhaps fate of the western aborigines.

The Aboriginal World cannot conceive of its emergence because the preponderance of colonizers has not been forced out and cannot in the foreseeable future be thrown out except by sudden and catastrophic natural events that would eliminate a substantial portion of the human species. If there is deliverance for the Aboriginal World it must come from God; it will most certainly not come within the course of events on the horizon. For that reason the Third World category is not only absurd for American Indians, it precludes the very conception of the Aboriginal category via which American Indians can be un-



Sioux

derstood.

The present interest in American Indians, albeit based more on the movie conception of the Indians of the last century than any profound knowledge of the people and conditions of today, assumes that somehow the immediate four centuries of conflict between red and white either did not really happen, or that they happened to groups other than those with whom we are dealing today. There is not much confidence in today's American Indian community that the concern which now flows like Niagara will have a lasting effect on the fortunes of the group. Indians are most probably the latest "camp" effort of a certain portion of the media. When the subject is consumed, a new topic will reign, if Women's Lib has not already taken center-stage, and Indians will be left to their unfriendly fate.

History, in American education, has tread the geographical path of colonial explorers and the time sequence of Christian theology. It has never been forced to confront the possibility of viewing man's experience from a definite place and a non-sequential time scheme. Insofar as it is an interpretation of facts and experiences, it is a tool for the justification of economic determinism and not a subject matter in which lessons are learned and wisdom gained. The reaction to the court martial of Lt. Calley should tell us that the American public has not learned its history and that incidents such as Sand Creek, My Lai, and the Phillippine massacres will be endlessly repeated in the future by the United States Armed Forces until such time as the citizens of the country can understand themselves as a nation and not as an inevitable process of development.

In spite of the superficiality of the present concern for the Indian, let us hope that some of what Indians are saying can break through 20 centuries of the unexamined social life of western man. While the battle between Aboriginal peoples and their conquerors will most probably be fought in the sphere of domestic quarrels over the remaining aboriginal land base, the conflict is in fact ideological and eventually religious. It is a choice between a conception of man as badly crippled sinner striving for approval, and man as mature individual satisfied in his existence and unwilling or unable to change.

THE American Indian, like the other aboriginal peoples, once owned vast areas of land. His religion, his political understanding, and his conception of economics all merged into a life-style which forbid exploitation of the land. In rather pre-Socratic thought forms, aboriginal man conceived land as a basic commodity comparable to water and air could not understand the western European desire to use land as a transferrable property that could be individualized and owned. The present concern with ecological disasters visited upon western man by his failure to recognize land, water, and air as social, and not individual, commodities testifies to aboriginal man's sophistication in his conception of universal values.

The struggle of the past four centuries has been one of two competing and mutually exclusive theories of land realized in political intrigues and wars of conquest. In this process, the theory of land "title" came to predominate legal thinking to the point where in the United States and Canada Indians achieve status, legal recognition, and social services primarily because they dwell upon lands held in a certain form of legal status, and not because they are citizens of either nation or because that nation's humanity dictates a just policy with respect to them.

Lurking behind this struggle for land was a conflict over the nature of man himself. The aboriginal peoples could not conceive of the individual as existing prior to his existence in the tribe or clan and were not particularly worried at his departure whether he had accomplished anything or not. Life was for living and only a fool would waste it with other considerations.

Western man could not abide this conception. It saw man as victim of an eternal warfare between good and evil, personified in God and the Devil. Man was destined to be on God's side and yet he had carelessly thrown in with the Devil because of his craving for apples. Man's task was to "make something out of himself" so that God would retroactively forgive him and place him among the Elect who would escape from this dreary existence to spend eternity playing musical instruments for God's pleasure.

Lands of the aborigines became instruments by which the lowest peasant could magically raise himself to the highest form of existence thus forcing God to admit him to the company of the Saints, a company which was predetermined, thus, justifying by its finality, every deed committed by the Elect while drawers of water and hewers of wood in this unhappy vale. It was a contest for the ultimate value of men's souls as well as their material well-being.

Political processes also reflected the difference in world-views. The aborigines, contemplating small closed societies in which individuals had definite places, realized that simple decisions required the approval of nearly everyone in the society, for it was the society that had to survive and not merely a part of it. Changing social factors characterized the western political processes and demanded only that a majority of people consent to proposed actions leaving an overwhelmed minority to accept change, to attempt to gain the majority to reverse change, or to move on. Society never attained stability for it was designed to avoid stability at all costs.

When the two political processes were combined within the emerging nations of Canada, the United States, and other countries, the result was predictable. Aboriginal peoples always believed that their colonizing opponents meant what they said regarding rights achieved by the aboriginal peoples in the various treaties and agreements. They looked upon the agreements as the legal means of stabilizing the immediate situation. The western Europeans considered the agreements as merely temporary means of quieting the natives until they were weak enough to disregard altogether. Time worked against the aboriginal peoples because they could not recognize its meaning for western Europeans.

As we view American Indians today, and particularly in this special issue, we must keep in mind two things: Indians have not yet left the aboriginal universe in which they have always dwelled emotionally and intellectually, and the western world is gradually working its way out of its former value system and into the value system of the aboriginal world. The alleged trend toward isolationism by the liberals may be a symptom, manifested in the political arena, that for a portion of American society, people are coming to accept a stable conception of the world and its processes.

Without maintaining an open mind and remembering the flexible and distinctive world-view of aboriginal peoples, readers will be tempted to draw from the articles of this issue enthusiastic programs for assisting American Indian people. Unless the reader keeps in mind the fantastic ability of Indian people to absorb the processes of western man and render them harmless and inactive in Indian society, the reader will be misled. And balanced against the ability to absorb, is the tendency of White society to view everything as an object of consumption. In short, for our purposes of discussion in this special issue on American Indians, the world, its air, water, lands, peoples, animals and plants, and the various nations and tribes that inhabit the globe, all exist for their own sake and not for our ability to change them, or for their inherent right to consume.

In this context, then, let us discuss the various areas in which American Indian people are working, speaking, thinking, and planning, and hope that the gulf that has existed between peoples may be bridged.

Perspective

by Elizabeth C. Rosenthal

Mrs. Rosenthal is a member of the Intercultural Studies Group.

Arapaho

"THIS is an ethnic era in American history; no institution, no field of work is exempt from the requirement of understanding our age in ethnic terms."[1] Every organization and educational agency is seriously pressed to review its functions, the nature and extent of its facilities, and its potential for service — and to make changes in accord with its findings. This issue of the *Harvard Medical Alumni Bulletin* takes a first look at the School in relation to the Native American community (American Indians, Eskimos, and Aleuts) in the United States.

The official census figure for Na-

Navajo

tive Americans in this country is 792,730, but the "hang loose" figure that Indian people use today is 1,000,000. This broader figure includes all of those on western federally-administered reservations and in Alaska, those in Indian communities in the East and South, and those in small towns and urban areas across the whole land. Up to one-half of the Indian people in the United States are now city people. Chicago, Los Angeles, Seattle, Denver, Washington, D.C., etc. are major centers of Indian population. (In greater Boston, the recently formed Boston Indian Council has identified a community of 3,000 Indian people.)

The issues of Indian health are now interlocked with problems of rural and regional medicine, inner-city social action and organization, Indian tribal history, and newly-evolving Indian inter-tribal politics. Those who tend to think of American Indians as a kind of "tail on the kite" in a minorities business, which is really about Blacks, do not get the feel of the Indian movement today. It is well to recall that "Indians came to America by the majority, not the minority route. Once they really were *everybody;* this is the strong and unifying tradition of Indian life and the heritage of each Indian person who maintains or renews his link with his tribe or the wider Indian fellowship."[2]

These days, from Indian perspective, America is dominated by a combination of Whites and Blacks. Both are "majority peoples" in politics, economics, and education. Native American students in college today are not just asking for a percentage piece of the "minorities education" pie, or for a fair share in "minorities admissions" in professional schools. They are asking for independent recognition as their own people, and for programs geared specifically to their needs, and the needs of the Indian community.

Ken Foster (Creek-Seminole) first-year student at HMS writes: "Harvard Medical School considers itself a leader in the medical world. They pinpoint crisis areas. If Indian health and education isn't a crisis, I don't know what is."

Don Bowen (Creek), from Oklahoma, states with deep concern that "many people are missing out on the opportunity to train Indian physicians, and it is so obvious that more of us are needed."

Native American health professionals are indeed needed. They can reasonably be expected to work more easily with patients of Indian cultural background and more effectively with Indian community leaders in the whole area of public health. But the need is deeper than that. The issues of Indian health will never be incorporated in the structure and fabric of professional medicine until Indian health professionals are themselves a significant part of that structure. Only then will Indian health be recognized as an area of abiding professional concern.

My grandfather was a gentle man and a scholar. His brother, a physician, stayed in upper New York State. Grandfather, an Episcopal minister, took his young wife and two infant sons and went to the Rosebud Sioux Reservation in Dakota Territory. Missionaries get the quick brush-off in most discussions of Indian issues, on the assumption that any and every minister who ever reached Indian country was a stealer rather than healer of souls — a proselytizer who scorned Indian tradition and culture — who used Indian people for his own emotional and spiritual enhancement.

As for grandfather, he simply made his home there and carried out his ministry. He went on as a scholar and a practical man — a linguist, a builder, a pastor, an advocate, a theologian. His professional colleagues were Dakota men who were themselves ordained to the ministry, and some who were medicine men in the old tradition. My father and my uncle grew up speaking the Sioux language and continued all of their professional lives in the Indian world. I grew up (White) on the Crow Creek Sioux Reservation and went off to college and graduate school. Eventually I found myself married and "relocated" in Boston — one of the first generation of reservation-born anthropologists.

It is relevant to recall this missionary era because the time has come again when the dominant society is urging some of its best professionals to get into Indian work, and urging Indian people to join company at the professional level. Good intentions are not enough now any more than 100 years ago; willingness to understand is not enough. There is homework to be done over long hours — genuine internship in Indian culture, problems, and politics — which must be required of the White or Black or Indian who enters the field of Indian health or education.

As Indian students come into the medical schools, men and women from medical schools must also go into the Indian world. This must be

done with care and conviction — not to "save the Indians" but in keeping with the highest professional standards of scholarship and practice.

Robert C. Buxbaum, M.D. reveals a keen awareness of the need for this approach in his paper on "The Role of the Medical School." He considers problems of Indian admissions to medical school (including problems in preparatory education). He sees the need for more working relationships between Indian Health Service and academic medicine. He points out the possibilities for cooperative programs of technical assistance between Harvard Medical School and organized Indian tribes and Health Committees. Similar cooperative programs could be developed with organized Indian groups in urban areas.

On reading Dr. Buxbaum's article, I find myself hoping also that he and others will specialize in Indian health and in the process, have a chance for advanced study in the field of Indian affairs. The papers by *Kenneth Prager* '68 and *Karl Singer* '67 indicate similar deep interest in Indian life combined with their professional medical concerns. All three of these men have found genuine intellectual and scientific challenge by way of their tours of duty in USPHS. It remains for them and for others to continue professional work *at this level* in company with Indian physicians *in this generation.*

George Blue Spruce, D.D.S. (Pueblo), director of a newly-created office of Health Manpower Opportunity in NIH, outlines clearly the steps that must be taken in the recruitment and training of Indian health professionals. He gives considerable credit to USPHS for its work in providing better preventive, curative, and rehabilitative health services to American Indians on federally-administered reservations over the past 16 years, and notes the real progress made in bringing Indian persons into the *health occupations* and *allied health professions.* But, he maintains, the breakthrough now must be in the *health professions* themselves.

Dr. Singer points out that the Navajo Indian language lacks terms for such basic Anglo medical concepts as "germs." Just so, English has no adequate terms for the Indian concept of "health," which is expressed in many different Indian languages. It can only be rendered in a whole constellation of English words: *harmony; beauty; balance; well-being; belonging; surviving; relating; kinship.*

A certain amount of esoteric interest has always been expressed in this Indian "set toward life," but few non-Indians have incorporated these concepts as genuine working tools in the health and service fields.

White and Black Americans have little in their own life-experience or professional training which prepares them to take the Indian pulse and pronounce the patient strong or weak, well or ill.

It is, therefore, important to note that each of the Indian writers in this issue conveys a sense of hope and health in the Indian present and future. Where visiting White Doctors see a bleak land, Indians and their everyday neighbors see a beloved country. Where outside observers read statistics and are startled and discouraged, Indian leaders review the same material, nod their heads, and persist in reporting that there are many signs of recovery. For Indian people, the facts of poverty, misery and sudden death are almost like old friends and relatives. They know all there is to know about them. Statistics don't change anything. What is encouraging are the new signs of life in the Indian world. That is what Indian people are reporting.

Vine V. Deloria, Jr. (Sioux) in his article "The Hidden Americans" interprets this new atmosphere of emotional and intellectual freedom, and clarifies its strength in community. The events of this past 10-20 years bear him out. The rebuilding of Indian identity is in process. History is being rewritten — not simply overcorrected in favor of Indians — but looked at in entirely new ways in the light of Indian philosophy, values, and vision. On the reservations, in the cities, and on college campuses, there is a kind of "dedication to survive and to thrive" (Bowen). Indians themselves seem moved by the discovery that they have made it through centuries of dishonor and hardship and are indeed still here.

There have also been significant political, economic, and educational strides in the past 10-20 years. If it were not so, this issue of the *Harvard Medical Alumni Bulletin* would not exist. There would be no discussion of recruitment and training of Indians for the health professions. No one would be talking about the possibility of "graduating a steady pool of Indian doctors each year." (Foster)

The Indian community has its own style of renewal — not the White way or the Black way. I must, therefore, challenge Dr. Prager's statement that "what is needed is a fundamental decision by the federal government to attack the problems of its Indian population head-on." I admire the enthusiasm embodied in this statement, but the abruptness, the "head-on" approach — no. Indians have been attacked enough, and Deloria calls on us to keep in mind the "fantastic ability of Indian people to absorb the processes of western man and render them harmless and inactive in Indian society." Better that we learn to practice principles of Indian health, harmony, relationship, and kinship.

What is needed is the quiet, persistent capacity to live with the problems we've got and work on them together through all of the institutions of our society — public and private. To achieve this, we will discover that Indians are needed in the health professions not only to serve Native American peoples, but to help us all.

FOOTNOTES

1. *A Statement of Objectives.* Intercultural Studies Group, 1970.
2. *Perspective on Intercultural Work in the Seventies.* Intercultural Studies Group, 1971.

HARVARD MEDICAL SCHOOL ANNOUNCES

The William O. Moseley, Jr.

Travelling Fellowships

THE BEQUEST OF JULIA M. MOSELEY MAKES AVAILABLE FELLOWSHIP FUNDS FOR GRADUATES OF THE HARVARD MEDICAL SCHOOL FOR POSTDOCTORAL STUDY IN EUROPE.

The Committee on Fellowships in the Medical School has voted that the amounts awarded for stipend and travelling expenses will be determined by the specific needs of the individual.

In considering candidates for the Moseley Travelling Fellowships, the Committee will give preference to those Harvard Medical School graduates who have—

1. **Already demonstrated their ability to make original contributions to knowledge.**
2. **Planned a program of study which in the Committee's opinion will contribute significantly to their development as teachers and scholars.**
3. **Clearly plan to devote themselves to careers in academic medicine and the medical sciences.**

Individuals who have already attained Faculty rank at Harvard or elsewhere will not ordinarily be considered eligible for these awards.

There is no specific due date for the receipt of applications or for the beginning date of Awards except that the Committee requests that applications not be submitted more than 18 months in advance of the requested beginning date. The Committee will meet once a year in January to review all applications on file. Applicants will be notified of the decision of the Committee by January 31. The Committee may request candidates to present themselves for personal interviews.

Application forms may be obtained from, and completed applications should be returned to:

Secretary, Committee on Fellowships in the Medical School
Harvard Medical School
25 Shattuck Street, Boston, Massachusetts 02115

Indian Health:

The Role of the Medical School

by Robert C. Buxbaum, M.D.

Manito: the Great Spirit

Dr. Buxbaum is assistant professor of medicine at P.B.B.H. and an internist at the Harvard Community Health Plan.

> *We shall learn all these devices the White Man has.*
> *We shall handle his tools for ourselves,*
> *We shall master his machinery, his inventions,*
> *his skills, his medicine,*
> *his planning;*
> *But we'll retain our beauty*
> *And still be Indian.*
>
> David Martin Nez, quoted by Steiner.[1]

To still be Indian is today a desperate struggle against a powerful enemy.

Centuries before the White settlers arrived, Indians were living in our country, with fully developed languages and customs. Yet most Americans lack even the most rudimentary knowledge of the Indian people. Although they share poverty, disease, malnutrition, and low educational attainment with other minority groups, the political and cultural aims of the American Indian remain separate, unappreciated by the majority.

Moreover, there is a special violence that characterizes White-Indian relations. For several generations, our culture has been fed a diet of fake Indian lore. Alternately romanticizing and trivializing him in the media, White society has perpetuated a political process whose only aim has been to destroy the Indian's identity. Proselytization, forcible deportation, massacre, "relocation," concentration on reservations, and denial of such basic American rights as the vote and education are all a part of the injustice committed against Indians. A few of these wrongs have been fully righted; others corrected at least in theory; but many, including new legal maneuvers, are still being perpetrated. Above all, the United States government, the legal guardian of Indians, has at its disposal the ultimate threat to their existence: the policy of termination, carried out with force in the 1950's and 60's, and even now a potential menace to every reservation tribe.

Other minorities have suffered similar or worse punishments. The difference however, is, that in the case of Indians, punitive actions have almost always been the result of *policy decisions* made at the highest level. Those making the decisions have been political leaders responsible to other constituencies. Indians make up only a tiny minority of our population. A whole people, the Pimas, could be denied access to water, and another, the San Carlos Apaches, flooded out of their homes to make way for a reclamation project, a move that was repeated a generation later in western New York, where the Iroquois were moved to make way for the Kinzua Dam. These are not violent acts; no one is killed, but a whole culture is denied the right to exist. Such acts do not occur spontaneously or without historic precedent. Consider this account of the massacre at Sand Creek, Colorado, in 1864:

Robert Bent, who was riding unwillingly with Colonel Chivington, said that when they came in sight of the camp "I saw the American flag waving and heard Black Kettle tell the Indians to stand around the flag, and there they were huddled — men, women, and children. This was when we were within fifty yards of the Indians. I also saw a white flag raised. These flags were in so conspicuous a position that they must have been seen. When the troops fired, the Indians ran, some of the men into their lodges, probably to get their arms. . . . I think there were six hundred Indians in all. I think there were thirty-five braves and some old men, about sixty in all . . . After the firing the warriors put the squaws and children together, and surrounded them to protect them. I saw five squaws under a bank for shelter. When the troops came up to them they ran out and showed their persons to let the troops know they were squaws and begged for mercy, but the soldiers shot them all. I saw one squaw lying on the bank whose leg had been broken by a shell; a soldier came up to her with a drawn saber; she raised her arm to protect herself, when he struck, breaking her arm; she rolled over and raised her other arm, when he struck, breaking it, and then left her without killing her. . . . There were some thirty or forty squaws collected in a hole for protection; they sent out a little girl about six years old with a white flag on a stick; she had not proceeded but a few steps when she was shot and killed. All the squaws in that hole were afterwards killed, and four or five bucks outside."

These were the Cheyenne and Arapahoe who had gathered at Sand Creek under government protection. Observers described in detail the systematic mutilation of Indian corpses which took place after the slaughter.[2]

During the past few years, a portion of the American public has become aware of the true history of the Indian in America. The critical and popular success of Dee Brown's *Bury My Heart at Wounded Knee,* and the reception given to Vine Deloria[3] and Stan Steiner's books on Indian political aims, are indications of a growing concern. Nevertheless, there is no body of public opinion large or prestigious enough to assist the Indians in reaching their goals, or a public conscience powerful enough to right the basic injustices that still exist.

Universities, and their medical schools, have been conspicuously absent from participation in Indian affairs. Some schools, notably Dartmouth and Harvard, have commitments to Indians engraved in their charters; yet the number graduated from these schools is miniscule. Anthropologic studies not withstanding, most universities have ignored Indian problems, and downgraded the importance of the issues. What they have done is add to the endless list of scientific studies of Indians, a process that understandably enrages Indian leaders.

In 1956, when I applied for a commission in the then Indian Division of the Public Health Service, no one at my medical school knew anything about that branch of the Service; today the situation remains basically unchanged, only slightly improved by the presence in various medical schools of a few former Indian Health Service officers.

It seems logical to support young physicians in their efforts to serve the Indian minority. It is, therefore, puzzling to discover that Harvard has little information available to students about this possibility. Even more mystifying is the failure of medical schools to ask questions about the state of Indian health. Systematic inquiry, even curiosity about the wretched health of these people, is totally lacking in most American medical schools. Yet, with all their resources, medical schools have much to gain from, and to contribute to, Indian health programs. Students, regardless of their subsequent choices, would gain invaluable cultural and medical experience by participating in such programs.

Medical school administrators often complain that they are expected to be all things to all people. No one really expects Harvard Medical School to adopt a reservation, underwrite a health program, or singlehandedly improve the health of Indians. In any case, these are the congressionally-designated tasks of the USPHS, a Service that functions efficiently and with a sensitivity not usually associated with a uniformed corps. But, there are significant areas of health care that need to be developed, and Harvard might well play an important role.

The most compelling need is to recruit Native American health professionals. Their numbers, at present, are miniscule. The block exists not at the interface between college and medical school; any Indian who finishes college and is otherwise qualified will most likely be accepted and financially assisted at medical

Chief Hollow Horn: Sioux

Medicine Men of the Chilkat Tribe

school. The real problem derives from the peculiarities of the Indian education system.[4]

FOR a large number of Indians, particularly in the Southwest, the Bureau of Indian Affairs is their educator. Huge boarding schools provide an experience almost inconceivable to those who have never witnessed it. Oriented toward unquestioning obedience, highly task-directed, destructive of all self-respect and identity, and designed to deliberately limit higher educational opportunities, these Dickensian schools exist in part because of the apathy of the general public, in part because of the rugged terrain and vast distances on many reservations, but mostly because of the bureaucratic intransigence of the BIA.

If Indians move to the cities, or are bussed to integrated high schools, serious barriers still remain because of the discriminatory attitudes of students, teachers, guidance counselors, and administrators. The chance that an Indian will be prepared for college is small; the chance that he will be encouraged to apply almost zero. Even if he applies and is accepted, the strangeness of the new environment, its competitiveness, and his lonliness usually conspire to discourage him. The dropout rate among college Indians is high. Thus, it should be no surprise to find that few are enrolled in graduate professional schools. Most Indian children have been educationally destroyed by the time they reach junior high school.

It is not a medical school's responsibility to reform the entire Indian education system, but it must appreciate the depth of the problem before it begins to think about training Indian health professionals. It is of transcending importance to provide role models for very young Indians, to begin early to give information and advice on health careers, and encourage college students to prepare for professional careers. The best way to provide this information is through the various tribal councils or their health committees.* Summer work programs, school counseling, field trips, and assistance in applying to higher educational institutions are all essential. For those who enter college, considerable help is needed to make the transition bearable. Programs such as Upward Bound are invaluable, but fill only part of the need. For the time being, Whites who are sensitive to Indian culture can help to bridge these gaps through personal efforts.

A serious and continuing effort to recruit Indians into health professions must be made. It is not enough merely to express interest or to forage through the reservations once in a while seeking qualified candidates. If the attempt is to be successful, recruitment must be by Indians, including those currently enrolled in college, administered by Indians, and the funds and staff controlled by Indian interests. Ideally, recruitment and counseling should be on a regional level, with groups of medical schools cooperating.

A second major area of medical school involvement is the provision of technical assistance. At present, a joint Apache-Harvard nutrition program is being discussed by interested parties from Arizona and the department of nutrition of the School of Public Health. The problems of nutrition, accident control, sanitation, infectious disease, maternal and child health, and alcoholism all would benefit from cooperation between Indian consumer groups and medical schools. Specific task forces could be formed with representatives from the tribes and the medical schools.

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*Any discussion of the role of White society in Indian affairs must begin with an understanding of the control Indians have over their own institutions. In 1934, with the Indian Reorganization Act, many tribes developed tribal councils, with elected representatives and chairmen. Although Indians make policy decisions on the local level, and to some extent, guide the development of their lands, they do not have even an advisory role in their educational affairs. The Public Health Service, in contrast to the Bureau of Indian Affairs, has committed itself to consult with Indians on matters of health policy. Indian Health Committees have been formed to review PHS programs and recommend new directions for the health system. Through the tribal councils and the health committees the important information about recruitment would best be transmitted to young Indians.

This raises an important question. What is the relation between a medical school and the Indian Health Service? At present the Service has virtually no formal ties with academic medicine. Unlike the National Institutes of Health and the Center for Disease Control, the Indian Health Service is not a prestigious stopping-off place for young physicians on the academic or specialty ladder. No individual at HMS has the responsibility for IHS programs, and no IHS officer has come to Harvard to speak about careers. Nevertheless, if IHS assignments were viewed with the same prestige as NIH positions, one would expect a larger interest on Harvard's part.

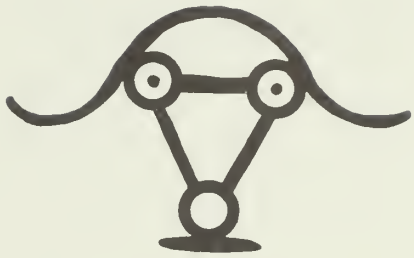
Harvard Medical School would benefit significantly if cooperative programs were to be established on Indian reservations. Such programs would broaden the clinical opportunities available to medical students. The IHS system consists of health centers, small hospitals, and medium-sized referral hospitals. Many of these stations, especially in the Southwest and Alaska, are isolated. Considerable responsibility is placed upon the staff, and while specialty referrals are made frequently (by airlift, if necessary), an officer quickly learns to handle most problems without the complex supporting staff available in university hospitals. A medical student placed in such a setting would learn clinical medicine, an exciting approach to public health practice, but, perhaps most important, he would be exposed to a different culture and its concept of health and disease. Permanent links to several reservations could be made, and the possibility of placing graduates in the field would thereby increase.

Almost every physician who has served in the Indian Health Service is enthusiastic about his experience. Counseling for medical students, and supervision and assistance for those interested in spending elective time in Indian Health Service stations could be provided by these physicians, if the Medical School approved. To a great extent, this would be an official response to the students' interest in community service, and in Indians in particular. It would be a chance to try this kind of assignment prior to making a commitment following graduation.

Even if the Medical School should agree to the importance of these programs, there remains a most important imponderable — the reaction of Indians themselves. The briefest contact with Indian leaders is enough to convince the most well-intentioned White professional that his services will not necessarily be welcome. The historic roots for this should be obvious. In this century, Indians have seen professors come and go. They have been the victims of study after study yet they have reaped no benefit. Unhappily, medical school faculty almost instinctively refer to any project as a "study," even if it is composed of only service components. To Indians, the word is inflammatory: they have been studied and restudied, and in general refuse to be the subject of any further outside-originated research.

Although much research remains to be done, it surely must be initiated by Indians and they must be active participants at all stages.

Hattie Tom: Apache



Living and working with Indians has been personally invaluable to many of us who served in the IHS. To return from the reservations and become involved with inner-city health projects seems a natural and logical step. A physician gains an understanding of the poor that no university training can provide. Our Indian experience initiated us into the politics of community control. We have learned how a majority deals with a helpless minority and how a petrified bureaucracy, the BIA, operates. Most valuable of all, we have established solid and lasting relationships with Indians.

At this point, medical schools lack the necessary resolve to work with Indians. There is little federal money available, almost no internal pressures, and even less external political force demanding help. Only the force of conscience exists, and it usually takes second place to the availability of funds. If, however, medical schools and the profession take an interest in the health of the entire nation, then Indians must receive equal attention.

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Alcoholism

and the American Indian

by Kenneth M. Prager '68

On a cloudy Saturday afternoon in November 1969, the two-way radio at the Public Health Service Indian Hospital in Eagle Butte, South Dakota, came alive with calls for help.

An officer of the Cheyenne River Sioux Reservation Tribal Police was requesting that a doctor and an ambulance be dispatched immediately to LaPlant, a small town on the reservation's eastern border, 30 miles away. Help was urgently needed for the survivors of a car accident that had just occurred. It sounded to me, the medical officer on call, as if this wreck was worse than most.

When I arrived at LaPlant, following a speedy drive in a makeshift ambulance over the vast South Dakota prairie, I was greeted by a scene of death and destruction. An enormous trailer truck was lying in a roadside ditch, its driver shaken but not seriously injured. On the other side of the road lay a demolished jalopy surrounded by the bodies of those who were either dead or dying. The stale odor of alcohol pervaded the wreck. The final toll of the accident was six dead, including several children. All of the victims were under 20. Ironically, a mentally retarded twelve year old girl and a twenty year old alcoholic were the only survivors. Later we learned that the driver of the jalopy had been intoxicated and was driving in the wrong lane when he collided head-on with the approaching truck.

Following the accident, I began to compile a list of every Indian death that occurred on the reservation. Though I had been in South Dakota only four months at the time, it had already become apparent that violent deaths were commonplace among the Indians of this tribe, and that alcohol was involved in nearly every unnatural death. Furthermore, it was obvious that young people were nearly always the victims of these senseless deaths. When I finished my two years in the Public Health Service (PHS) in June 1971, the data I had compiled told a staggering tale. (Table I).

Of the total deaths on the reservation during my two-year stay, 53 percent were unnatural or violent. Equally striking was the average age of death — 24 years. Sixteen Indians died in auto wrecks, four of suicide, one of drowning, three of freezing, and two were beaten to death. Three of the four suicide victims were young men who hanged themselves while in the tribal jail. In almost every case of violent death, the victim either showed signs of alcoholic intoxication at the time of death, or died as the result of someone who was intoxicated.

These statistics are not unique to the 4,100 Sioux living on the Cheyenne River Reservation. The latest health statistics compiled by the PHS[1] show that accidents have been the leading single cause of American Indian and Alaska Native mortality annually since 1955, when these figures first became available. Accidents account for one of every five Indian deaths. By contrast, accidents are the fourth leading cause

TABLE I

INDIAN DEATHS ON THE CHEYENNE RIVER RESERVATION

July 1, 1969 - June 30, 1971

Category of death	*Number*	*% Total Deaths*	*Average Age At Death*
Natural Causes	23	47	54*
Unnatural Causes	26	53	24
Total:	49	100	

* Included in this category:
6-month-old child who died of "crib death"
7-year-old boy with cystic fibrosis
2-week-old infant with pneumonia
1.5-year-old child who died of sepsis secondary to an infected shunt for hydrocephalus

If these four pediatric deaths are excluded, the average age at death of those who died of natural causes jumps to 66 years old.

of death in the general U.S. population, where they account for one of 17 deaths. What is not documented in these statistics is the percentage of accidental deaths in the Indian population related to alcohol. Extrapolating from my experience on the Cheyenne River Reservation, I would say this percentage is considerable. Because those who die from accidents tend to be in a young age group, there is a marked discrepancy in the distribution of deaths by age group between the Indian and non-Indian populations. In 1967, the most recent year for which figures are available, 45 percent of Indian deaths were in the age group below 45, whereas only 14 percent of the total number of deaths in the non-Indian population occurred in this age group.

It would be an oversimplification to explain these depressing statistics merely by pointing to alcohol-induced traumatic deaths. There are other major factors to consider. Inadequate housing and poor sanitation on many reservations leads to a high incidence of fatal pneumonias and dysentery in the pediatric age group. On the Cheyenne River Reservation, however, the health problems posed by alcoholism are of foremost concern, and are representative of many other Indian reservations.

It should be noted that tuberculosis, once a scourge among the Indian population, has declined dramatically as a cause of death. This trend continues. From 1955 to 1967 the number of Indian deaths attributed to tuberculosis dropped from 251 to 91. Chemotherapy, better housing, and improved health care account for the striking decline in tuberculosis mortality. An elderly diabetic woman, who presented with far-advanced miliary disease, was the only death from tuberculosis while I was at Eagle Butte.

Mortality statistics tell only a small part of the relationship of alcohol to Indian health. Alcohol-induced morbidity is even more striking. The second most common cause for admission to all PHS Indian Hospitals is trauma. A significant number of these admissions are related to alcohol. Add to this the enormous psychopathology and family disruption caused by the prevalence of alcoholism on the reservation and one can begin to appreciate its toll in human suffering.

As it gradually became clear to me that alcohol was the number one health problem on the Cheyenne River Reservation, I began to wonder what led so many of the reservation's young people to begin drinking, and if there was anything the PHS could do to stop them once they had started. My initial enthusiasm to form an alcoholism program was tempered by the utter failure of similar ventures on the part of PHS physicians at Eagle Butte in the past. Antabuse, group therapy, an Alcoholics Anonymous group, and careful individual follow-up had all been tried but the success rate was nearly zero. A few alcoholics had been sent to the state mental hospital at Yankton in a gesture at rehabilitation that was as pathetic as it was futile. It was usually only a matter of days following his return to the reservation before the "rehabilitated" Indian resumed drinking with his unrehabilitated colleagues.

Reservation dwelling

As for its availability, alcohol is readily obtained from several bars scattered over the reservation. Although the bars are closed on Sundays and holidays, several bootleggers operate profitably, and with impunity, in the Indian quarter of Eagle Butte. Although marijuana is occasionally smoked by a few students, heroine, amphetamines, and LSD are rarely used.

To appreciate why an Indian youth emulates his elders and begins drinking heavily, some appreciation of his past, present, and future is necessary. Once proud warriors of the great plains, hunters of the buffalo, victors over Custer, and the people of Sitting Bull, the Sioux today are among the most depressed — emotionally, culturally, and economically — of all their Indian brethren. Hollywood has amply documented the fact that, in spite of their fierceness and bravery, the Sioux finally lost their battle with the U.S. cavalry. Unfortunately, Hollywood stopped there. For an account of what then happened to the Sioux, one should refer to the current best seller, *Bury My Heart At Wounded Knee,* which is an historic account of the criminal way in which the federal government, after defeating the Indians militarily, proceeded to cheat them of their lands, destroy their pride, and enfeeble their culture. A misguided government policy sought to forcibly assimilate the Sioux into American society by placing their children in boarding schools where, among other restrictions, they were forbidden to speak their native tongue. Although this policy of forced assimilation failed to remake the Indian in the image of his conqueror, it succeeded in suppressing the Sioux language and culture. The disappearance of the buffalo and the open range, the confinement of Sioux to reservations, and pursuit of cultural genocide, through the suppressive policies of the government boarding schools, nearly destroyed the Sioux culture, but did not replace it with another.

In this context it is not difficult

to understand the crises of identity facing today's young Sioux. A telling commentary on just this point is the fact that the Sioux child who goes to the movies in Eagle Butte cheers for the cowboys and cavalry officers in their screen battles with the Indians. I was equally surprised when the mothers of Indian children who were brought to the hospital would attempt to stave off the inevitable bouts of crying by admonishing their children to be "brave cowboys," never "brave Indians."

The Indian child's image of himself is all too often formed from seeing his intoxicated elders and the insulting Indian caricatures popularized in movies, on TV, and in books. Insecure in the White man's world, and bereft of the virtues and sustenance of his own culture, the young Sioux stagnates on the reservation and drinks.

The economic picture on the Cheyenne River Reservation is bleak. The 4,300 square miles of reservation are comprised of rolling, treeless prairie, best suited for cattle grazing. There are no economically significant natural resources other than grass. Drinking water is of poor quality. There is little precipitation and extremes of heat and cold prevail. Of the 6,200 enrolled members of the Cheyenne River Sioux Tribe, 4,200 live on the reservation.

Only a handful of these Indians operate successful cattle ranches. Over the past decade, some 225 families have failed in a government-subsidized attempt to set up economically viable ranching enterprises. Most of these families today are heavily in debt. Although sloppy management and alcohol are most often cited as the reasons for their failures, other factors such as inexperience, poor training, and the absence of an entrepreneurial ethic in Sioux culture are undoubtedly equally responsible. The notion of acquisition solely for the purpose of personal gain is a concept alien to Sioux culture. Indian ranchers shared their cattle with needy family members rather than operate exclu-

sively by the profit motive. It is of note that most of the Indians who have succeeded in ranching are "breeds," part Indian and part White.

Unemployment is prevalent on the reservation. Most of the Indians who have jobs do seasonal ranch or farmwork for low wages. There is no industry on the reservation. The Tribal Council, the Bureau of Indian Affairs (BIA), and the PHS employ a limited number of people. A major source of employment is the federally sponsored Community Action Program under the Office of Economic Opportunity. Under CAP, various programs are funded such as public works, assistance to the elderly, and teacher's aides. Fifteen percent of the people on the reservation must receive BIA financial assistance during the winter months when employment opportunities drop. In addition, a sizable number of families obtain funds from state and federal welfare programs.

Upon reaching the age of eighteen, every enrolled tribal member receives a $1287 payment from the federal government known as the Sioux Benefit. This is the payment owed to each member of the tribe by the U.S. government to compensate for the loss of tribal land inundated by waters that accumulated behind the recently-constructed Oahe Dam. All too often this money is spent rashly in a wild celebration with friends and family. The hulks of wrecked automobiles known as the "Sioux Ben Cars" may be seen along the roadside. These wrecks resulted from sprees of drunken driving during the celebration of the Sioux Benefit.

EDUCATION on the Cheyenne River Reservation is abysmally poor. The high school dropout rate for Indians is nearly 50 percent. Only a handful of Indians go to college; even fewer obtain college degrees. Schoolwork is often irrelevant and poorly taught. It is remarkable that only within the past several years has an elective course in Sioux language and culture been introduced. Virtually none of the Indian students at the BIA school in Eagle Butte has ever heard of, much less read, the recent books by Vine Deloria, Jr., an articulate Sioux spokesman from a reservation just north of the Cheyenne River Reservation. His book, *Custer Died For Your Sins,* is an incisive and witty discussion of the present problems of the Indian in the context of past U.S.-Indian relations. In addition to student ignorance and apathy is administrative disapproval of what is deemed to be a "radical" book. One of the few Indian students who bothered to read it told me that the principal of the BIA school refused to let him enter the building while carrying the book.

Compounding the gross inadequacies of the educational system are the inevitable problems of dormitory life for the students. The BIA school in Eagle Butte is a boarding school, but its resemblance to such illustrious counterparts as Andover and Exeter is in name only. School dormitories on the reservation are a necessary evil because of the numbers of children who live too far from the school to commute, and because of a substantial number of

"Sioux Ben Cars"

children who must be removed from intolerable home situations.

The students in the dormitories lead a regimented, lackluster existence, and receive only minimal personal attention from the overworked matrons. There is one matron for 60 pupils. The finished product of the boarding school system is often a withdrawn adolescent, with minimal ego strength, poorly-educated, lacking any marketable skills and no plans for the future. The young men follow the pattern set by their predecessors, obtain seasonal employment when available, and often, if they have not started already, begin drinking. The great majority of young women marry early and begin to raise large families. The cycle of poverty and family instability is thus perpetuated as these young men and women marry and raise children, having as their only models for family life the disrupted households from which they came, complemented by the emptiness of a childhood and adolescence of boarding school existence.

IN the face of all these tribulations, and with a history of repeated governmental deception, the Cheyenne River Sioux are not political agitators. They are strangely silent. In fact, they are patriotic and consider military service on behalf of their country a great honor. If they are angry at the White man for their desperate situation, it is not readily apparent. In contrast to the city ghettoes, it is safe to walk through all sections of Eagle Butte at any time of day or night. This Indian passivity and silence, however, is deceptive. Mild alcoholic intoxication is all that is needed to allow the seething, repressed hatreds and frustration to surface. Unfortunately for the Indians (fortunately for the White man) these hatreds, once unleashed by alcohol, are directed both inwardly and towards members of the immediate family. Wife beatings by intoxicated husbands are common. Recurrent episodes of wild drunken driving, leading to serious injuries and death, represent this prevalent self-destructive tendency of the Sioux. In the younger age groups, especially among the dormitory students, suicidal gestures, breath holding contests, glue-sniffing, and self-maceration are common. Only rarely, on the other hand, are epithets hurled at White people; even more uncommon are instances of Indian attacks on Whites.

Among Indian tribes, the Cheyenne River Sioux are not alone in their inability to obtain substantial and innovative governmental programs to rescue their reservation. An insight can be gained into some of the reasons behind the political weakness of the American Indian if we compare his plight to that of the Black American who, in contrast, has made significant political, economic, and educational strides in the past decade. Though both Indians and Blacks are disadvantaged minorities, the similarity ends here. There are 22.5 million Blacks; there are only 650,000 American Indians and Alaska Natives. The Blacks are concentrated in the cores of the major cities. Their protests are given prominent coverage by the news media. By contrast, roughly two-thirds of the Indians are dispersed among isolated reservations in some of the most sparsely-populated states. The few, organized Indian demonstrations that *are* held do not disrupt the lives of many Whites and are scarcely noted in the press or on TV. Only the confrontration tactics used in the seizure of Alcatraz created more than a flurry of interest. Aside from that episode, and but for the tradition-

AMERICAN INDIAN STATISTICS*

1. Population: 650,000
2. Indian unemployment is nearly 40 percent — more than 10 times the national average.
3. Forty-two percent of Indian schoolchildren drop out before completing high school.
4. The life expectancy for the Indian is 64 years compared to 70.5 years for other Americans.
5. Fifty thousand Indian families live in unsanitary, dilapidated dwellings.
6. Indian infant mortality rate is 32 per 1,000 births — 10 points above the national average.
7. Fifty percent of Indian families have cash incomes below $2,000 a year, 75 percent below $3,000.

* The New York Times Encyclopedic Almanac, p. 301, 1970 ed.

al campaign season visits by suddenly-concerned politicians, the Indians are simply not in the news. In a country where publicity is a *sine qua non* of effective political action, such isolation and silence are major obstacles.

Compounding these problems is the lack of intertribal cooperation and planning. Whereas Black soul brothers unite readily for common goals, Indian tribes, with their separate languages, cultures, and local interests, find it far more difficult to plan and execute coordinated political action. Another drawback to the Indian cause is the absence of a leader with the public stature of Martin Luther King or Malcolm X. In addition, the ranks of future Indian leaders are depleted by the BIA. By incorporating into its bureaucracy those educated Indians who might otherwise have entered political life and sought changes in the Indian *status quo*, the BIA saps the tribes of their potential political activists and undermines the strength of Indian protest.

At the present time in American history, we are, therefore, faced with a glaring contrast. On the one hand is an increasingly united Black community, heartened by the successes of the sixties and looking forward to continued change; on the other, an inarticulate, poorly-educated, disorganized Indian community, whose problems have been analyzed and re-analyzed, and for whom the prospect of significant change in the near future is unlikely.

THE Cheyenne River Sioux Reservation epitomizes the deepest and most intractable problems of the American Indian community today. Its leaders are bereft of ideas and often reactionary; it is depressed economically; its educational system does not educate; its culture is becoming weaker. The federal government, ultimately responsible for this debâcle, contents itself with ensuring the physical survival of the Indian by providing him with food,

The three generations of the William Deer family epitomize the problems of the Cheyenne River Reservation on a personal level.

William Deer

Bill is a hearty and likable man in his late sixties who often appears at the hospital complaining of chest spasms that are always relieved by injections of saline. He has many friends, partly because he inherited much land from his aunt, which in time he began to dispose of in a reckless fashion. With the money from leasing and selling his land, he would buy new pickup trucks, houses, clothes, and alcohol for his friends and relatives. Bill's generosity was in the best Sioux tradition; by American society standards, however, he was an irresponsible wastrel. The tribal government finally clamped down on him and now is carefully supervising his land. Bill Deer illustrates the manner in which Sioux values and traditions have become distorted in the context of a radically new society.

Charlene Poor Weasel

Bill's step-daughter, Charlene Poor Weasel, is an intelligent and perceptive 24-year-old mother of six, who is trapped on the reservation by invisible but powerful forces. Charlene married in her early teens and had her six children in rapid succession. In an effort to escape the alcoholism and despair of the reservation, she, her husband, and their children, went to Texas on a BIA-sponsored relocation program. Within two years, Charlene and her children were back on the reservation. Her husband had continued to drink heavily in Texas and was unable to hold his job as a mechanic. During an alcoholic debauch he molested Charlene's seven-year-old daughter who was born out of wedlock and fathered by another man.

Following her return to the reservation, Charlene was jailed for child neglect. After her release from jail, and following a period of valiantly trying to care for her children in the absence of a husband and in the presence of an alcoholic sister and brother-in-law, Charlene began to drink as well. Her children were taken from her and placed in temporary foster homes while she was voluntarily committed to the alcoholism ward at Yankton State Hospital. Following a stay of several weeks at Yankton, Charlene was discharged by her psychiatrist who felt that her prognosis was poor and that she was "ungrateful" for all the efforts made on her behalf. Charlene returned to the reservation

shelter, and medical care. In the absence of effective political pressures on Washington, no innovative programs in such fields as education or economics have been forthcoming. Is it any wonder, therefore, that the Indians of the Cheyenne River Reservation, as do those elsewhere, turn to alcohol? And if, as previously noted, alcohol is the number one health problem on this reservation, can the PHS ever cope with this problem as long as the factors which spawn drinking persist? How likely is it for the mortality statistics of the Cheyenne River Sioux to change substantially over the coming years as long as there are children in the tribe who shuttle between the anomic of a government boarding school and the disaster of an alcoholic household?

in a state of limbo not quite knowing what to do. She resumed drinking. At Charlene's request, her children have been returned to her. She often speaks of suicide. She has been abandoned by her fundamentalist pastor who feels that she is an incorrigible sinner. Occasionally, she entertains the idea of training as a nurse's aide in the city once all of her children reach school age. Even now her eldest daughter is obviously emotionally disturbed. Her other children possess the withdrawn, apathetic features so characteristic of many of the children on the reservation. The outlook for Charlene and her children is grim.

Michael

Bill's grandson, Michael, is seventeen-years-old. His mother died in a car wreck. His father abandoned the family when Michael was a child and died soon after of alcoholic liver disease. For a while, he was raised by Charlene. While in the BIA school, Michael was bright, but unruly. He was placed in a program called A Better Chance (ABC) and was sent to Vermont where he attended high school. Michael found the work difficult (his BIA schooling was inadequate) but challenging. For a while he enjoyed his new life. He was promised a place in an Ivy League College if he completed high school. In the second year of the program, Michael began to feel uneasy. He wanted to return to the reservation, if only for a while, to see where he stood in relation to his people. In an attempt to capture the essence of the Sioux tradition, he undertook an oral history project, roaming the reservation and tape recording the thoughts and memories of the older Sioux. Michael never returned to Vermont. He befriended a red power advocate and was arrested with other young Indians for attempting to climb Mount Rushmore during a protest for the return of the Black Hills to the Indians. (Following the discovery of gold in the Black Hills of South Dakota, this area, sacred to the Sioux, was seized by the federal government in direct violation of a prior treaty.) Soon thereafter Michael married and he will soon be a father.

Michael was the most articulate young Indian I met in Eagle Butte. Because of his insight into the magnitude of the problems facing his people, he was perplexed and overwhelmed. He wants desperately to live his life as a Sioux Indian, but he is not sure what that means in this country in the 1970's. His years in Vermont gave him perspective but no answers. He wants to stay on the reservation and help his people but he is not as yet sure of how, and there are few people on the reservation to help him find the answer.

Fortunately, there are some hopeful elements in this otherwise depressing picture. The Sioux have a heritage of which they can be proud. Each summer, substantial numbers of them congregate at powwows held on various reservations. Traditional dances, songs, and costumes mark the occasion. If appropriate efforts were made, these powwows could serve as the nucleus for a revitilization of the Sioux culture, especially for the youth. In the economic field, other reservations have well-established or fledgeling industries that will hopefully enable their people to obtain gainful employment without having to leave their homes for the alien surroundings of the cities. A demonstration school for Navajo children in the southwest has shown significant improvement in the quality of education provided for the Indians of that tribe. With adequate funding, similar schools could be built for the children of all tribes.

What is ultimately needed is a fundamental decision by the federal government to attack the problems of the Indian population head-on. Professor Charles Issawi, an economist at Columbia University, stated as a "law of social motion:" ". . . most societies do not reform abuses until the victims begin to make life uncomfortable for others." At the present time, the American Indian, undoubtedly one of this country's most neglected and betrayed minorities, does not have the means or the numbers to make life uncomfortable for others. Aware of this, he only too often drowns his rage in alcohol and vents his anger and frustration on himself and his family.

Hopefully, however, Professor Issawi will be proven wrong.

Hopefully, the United States will redress the grievances of the forgotten American before, if ever, it is forced to do so.

FOOTNOTES

1. *Indian Health Trends and Services*, 1970 edition, Public Health Service Publication No. 2092, January, 1971.

How the Navajo Deals with Illness

by Karl L. Singer '67

THE 125,000 Navajo Indians in the United States comprise one-third of the total American Indian population, and are the largest, single tribe. The Navajo reservation covers 25,000 square miles, nearly half the size of New England. A semi-arid plateau, it is situated primarily in northeast Arizona, but extends into New Mexico, Utah, and Colarado.

The size of the reservation, and the absence of paved roads prior to 1955, has allowed much of the traditional Navajo culture to survive until the present. One of the most important areas of this culture is its manner of dealing with illness.

I recently completed a two-year tour of duty with the Public Health Service, during which time I was stationed at an outpatient clinic in Chinle, Arizona, a small community in the center of the reservation. The manner in which the Navajos deal with illness and the place of Anglo medicine in their lives are unique and fascinating. (Navajos use the term "Anglo" to describe any White American and do not limit the term only to those of Anglo-Saxon descent.)

Maintaining the proper balance between himself and all aspects of his environment is the Navajo's major concern. Not only must man and all elements of the natural world be in balance, but man and the supernatural must also be in harmony. Health, or a feeling of well-being, signifies that such a balance has been achieved. Since this balance is a dynamic one, a Navajo must continuously practice the correct behavior in dealing with the elements of his environment. "Thus it is that disease is perceived by the Navajo as a state of disharmony caused by a transgression of the proscribed behavior or by witchcraft."[1]

The following are examples of proscribed behavior; a son-in-law looking at his mother-in-law's face, entering a house that had been abandoned because someone had died in it, or killing a sacred animal, such as a bear. Violation of such proscriptions can lead to illness immediately or even after many years.

Illness may also be caused by the actions of witches. Witches are special people with unique training who have power over others. This power, often acquired by gaining possession of material like a fingernail or hair clippings from the person who is being witched, derives from the witch's contact with the dead. "Witchcraft is obviously a means of attaining wealth, gaining women, disposing of enemies, and 'being mean' . . . a potential avenue to supernatural power."[2] There are several varieties of witches described by Kluckhohn; each causes a different type of illness.

When certain symptoms occur, a Navajo knows that he is ill or out of harmony. In addition to the familiar ailments, such as cough, pain, and headache, there are a number of culture-specific complaints, most notably a lazy-like feeling or a crooked face.[3] The type of presenting symptom is used in deciding whether there is any value in seeking attention from the Anglo doctor. All children and patients with broken bones or pain from a specific location are usually seen by the Anglo doctor, while people with bad dreams rarely go to a clinic. There is also a middle ground of patients with symptoms such as arthritis who may or may not seek attention.

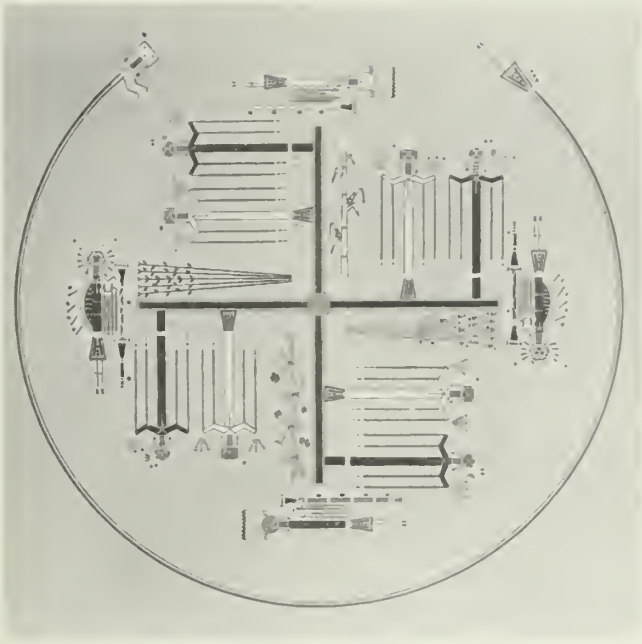
THE underlying concern of all Navajos, however, whether or not they seek symptomatic relief from the Anglo doctor, is to discover the cause of their illness. Only by discovering the specific proscribed act that led to the illness can the Navajo hope to regain harmony. This is in marked contrast to Anglo culture, where the primary desire is symptomatic relief.

The Navajo curing system has two major parts. The first, or diagnostic part, is to discover the specific proscribed behavior. The second, or curing part, is to perform the proper healing ceremony.

The first stage of the process is carried out by a diagnostician, who is either a hand-trembler or a star-gazer. These diagnosticians, whose power comes from a sudden calling at some point in their lives, enter a trance and reveal the proscribed behavior. During this initial ceremony, the patient is not asked any elaborate questions about the nature of his illness. Rather, through mystical revelation, the diagnostician helps to point out to the patient the cause of his illness. This is only a preliminary diagnosis, used to suggest the proper singer and the specific type of ceremony required. The act of diagnosis is considered relatively simple, and the diagnostician has only a mid-position in the hierarchy of Navajo healers.

The highest place is held by the singer or *hatathli*, the man who actually completes the diagnosis and performs the curing ceremony or "sing." Only after many years of apprenticeship is a man considered a competent singer.

There are 35 basic ceremonies, with many different variations, that last from two to nine days. Patient and doctor discuss which particular part of the ceremony might help and decide jointly on the therapy. During the ceremony, the singer chants ritual melodies, prepares drinks of herbs, dances, and constructs sand paintings, which are stylized traditional pictures made of colored sand on the floor of the ceremonial house.



This sand painting, called "Whirling Logs," is part of the Nightway Chant. It includes representations of a number of different gods as well as the four sacred plants: white corn, gray bean, yellow squash, and black tobacco. The circle in the center is where the Navajos emerged into this world, and the four logs represent the four directions.

In the past, a person who required symptomatic relief went to an herbalist, a man versed in the use of native herbs, who could also perform minor surgery, such as setting bones.

Today, however, symptomatic relief is provided at the facilities of the Indian Health Service, a branch of the United States Public Health Service. This branch was created in 1955 when responsibility for providing health care to reservation Indians was transferred from the Bureau of Indian Affairs in the Department of the Interior to the Public Health Service of the Department of Health, Education, and Welfare. The complete range of medical services, including dental care and drugs, is provided without cost. Prostheses, such as eyeglasses and artificial limbs, are the only major items not provided.

On the Navajo reservation, services are provided at two outpatient clinics, five small to medium-sized hospitals, and one large referral hospital. These facilities are staffed by 100 physicians, approximately 30 dentists, and a full complement of auxiliary personnel, including pharmacists and sanitarians. Over 50 percent of the employees are Navajos, but there is only one Navajo physician. The vast majority of medical care is provided in these facilities; a few, highly specialized services are provided at referral centers in Albuquerque, Phoenix, and Tucson.

Practicing medicine on the reservation poses many problems. Often there is a language barrier because many Navajos have difficulty with English and few Anglos speak even rudimentary Navajo. Most of the history taking, therefore, is done by translators, usually nurses. Complicating the problem is the fact that the Navajo language lacks terms for such basic medical concepts as "germs."

Most physicians stay in the PHS only for the two years required to fulfill their draft obligation. Because they usually know little or nothing about the Navajo when they arrive, they must spend much of the first year learning the culture. Just as they have begun to understand the problems, they leave. The Navajos, understandably, are unhappy that the doctors come and go so quickly. The pace of their culture is much slower; two years is barely enough time for more than an introduction.

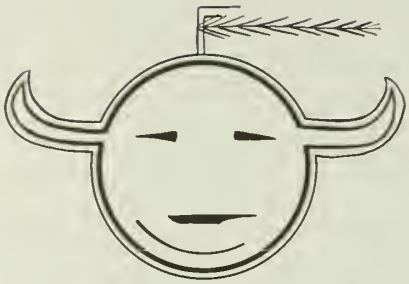
Most physicians enter the PHS after completing their internship. Physicians then return for residency training after completing their tour of duty. The Navajo interpretation of this is that partially trained "interns" come to the reservation to practice on Indians.

Distance is one of the major problems in medical care delivery. To reach a health facility, patients must occasionally travel more than 100 miles over dirt wagon trails that can wash away during rain or snow. There is no public transportation, and a patient without his own vehicle (this means most Indians) must "catch a ride." This can be expensive, often costing $20.00 and, even if the patient has the money, it might take days to find someone who is free to drive to the clinic.

Problems also arise when there is a conflict of expectations. The primary action of the Navajo therapeutic experience is talk and personal contact between the hand-trembler or singer, and the patient. The Anglo doctor, on the other hand, relies largely on his physical examination; he cannot take a history except through a translator. To Navajos, this type of examination is similar to the way a veterinarian treats an animal.

Another type of conflict revolves around the concept of what represents an illness. Many Navajos are born with congenital dislocation of the hip. To the Navajos, this condition was not an illness because it did not interfere with their way of life. To Anglo doctors, however, it was an illness, because of the cosmetic problem of a limp, and because of the tendency to develop arthritis in the joint at an early age. Their initial treatment was to fuse the hip. Many Navajos underwent surgery, but were unhappy with the results, because a fused hip made it impossible to sit on the ground with their friends.

Occasionally, an Anglo physician will suggest that a patient might benefit from a sing; sometimes a singer will suggest that a patient should go to the hospital before having a sing. As an example, a man fell off a horse and was taken to the hospital to be observed for possible consequences of a head injury. After two days, he left the hospital against advice because he wanted to have a sing performed. By the time he arrived at the sing, he was having difficulty with his speech. The singer told him to return to the hospital to have the blood clot removed from his brain. He immediately returned to the hospital where emergency surgery revealed a subdural hematoma.



Navajo

One unusual example of cooperation between the Anglo and traditional systems of medicine is a grant from the National Institute of Mental Health to one of the schools on the reservation to set up a program to train young men as singers. Funds are provided to pay part-time salaries to six medicine men, and stipends are given to six trainees who are serving their apprenticeship. All work closely with one of the PHS psychiatrists and share thoughts on how to deal most effectively with various psychological problems.

Medicine man prepares sand painting.

In spite of all the problems, the medical care delivery system on the Navajo reservation is among the best in the United States. First, because the PHS has responsibility for all aspects of health care, including both preventive and curative services, it can allocate funds and resources in a manner that corresponds to relative health needs. Second, because the patient does not pay for his care, he gets what he needs and not merely what he can pay for. Third, because the facilities are arranged in a hierarchial fashion, duplication of resources is avoided.

While the health care delivery system on the reservation is generally good, the Navajo people are not particularly healthy. The infant mortality rate is higher and the life expectancy is shorter than that of the American average. While more doctors and health facilities are needed, the real answer to these problems lies in the provision of better food, more adequate housing, running water, and improved transportation.

In summary, health care on the Navajo reservation, while far from perfect, is better than that available to many Americans. Not only is high quality Anglo medical care available to all to deal with the symptoms of illness, but there is also a viable religious system that deals with the emotional concomitants of illness.

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Needed:

Indian Health Professionals

by George Blue Spruce, Jr., D.D.S. M.P.H.

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Pueblo

"The first Americans — The American Indians — are the most deprived and most isolated minority group in our nation. On virtually every scale of measurement; employment, income, education, and health, the conditions of the Indian people ranks at the bottom. . . ." So said President Nixon in his message to Congress on July 8, 1970.

In this article, I will touch on two of these categories, education and health; more specifically, the need for American Indians in the health professions.

Some background information should be provided. There are over four million people engaged in providing health services. Two hundred different categories comprise the spectrum of Health Careers, the training periods for which vary from several weeks to as many as 12 to 14 years.

In the past ten to 15 years, there has been a change in the concept of health care and its delivery. No longer do people view health and its provision as a service available to only a select few, but rather as the right of every citizen. The increase in the demands for these rights has added to the ever-increasing health manpower shortage.

Recently, the federal government has increased its programs and expenditures in the area of health manpower training to alleviate the shortage. New health profession schools have been built and federal dollars have been given to institutions to help in their day to day operations, as well as encourage them to increase enrollment and shorten curriculum.

As an industry, health ranks second only to defense in terms of expenditures. Last year, the federal government spent 19 billion dollars for various health programs; the nation as a whole spent 70 billion dollars.

My concern is that relatively small amounts of these dollars go to American Indians for their much-needed health programs. Statistics show that the American Indian has a shorter life span than the non-Indian. This is attributed not only to adult deaths, but to an exorbitant infant mortality rate. Current statistics reveal that for every 1,000 Indian babies born, 32 die, whereas for every 1,000 non-Indian babies born, 22 die. Those Indian babies that survive the first month, but die within the next eleven months, have a mortality rate of 17 per 1,000, as compared to the non-Indian population of 9 per 1,000. Not only does the American Indian suffer from diseases specific to him as a member of an ethnic group, but he is a victim of diseases such as trachoma, otitis media, bronchitis, pneumonia, hepatitis, scarlet fever, and tuberculosis, to a much greater extent than are non-Indians. Dental problems, such as periodontal disease and missing teeth, are more severe among Indians, and Indian children exhibit a number of gum diseases that the texts describe as occurring only in adults. Without question, the suicide rate among young adults is the highest in the nation.

This is, indeed, a sad commentary, especially when we compare it to what was written about the health of the Indians by the early foreign explorers. In one of his first letters back to Spain, Columbus commented on the absence of deformity among the Indians. The French essayist, Michel de Montaigne declared: "It is rare to see a sick body amongst them." William Wood, referring to the New England Indian wrote: "Most of them reach fifty before a wrinkled brow or grey hair betrays their age." A Dutch account related: "It is somewhat strange that among these people, there are few or none that are blind, or crippled; all are well fashioned people, strong of mind and body, without a blemish. . . ."

It is pitiful to witness the change that has taken place. But, in all fairness, health conditions were much worse 16 years ago when the Indian Health Service (IHS), an agency of the United States Public Health Service (USPHS) was given the responsibility of providing preventive, curative, and rehabilitative health services to the American Indian, specifically, those Indians located on the more than 200 federally-administered reservations. The IHS has had dedicated health professionals and its leadership has wanted to do

more than it has been able to, yet the same story prevails — the limited allocation of funds.

More personnel, facilities, and better methods for rendering health care to the Indians have been provided over the years. When I joined the Service in the late 1950's, there were only 40 dentists to treat the entire Indian population; now there are more than 150. There were 130 physicians; today there are over 400. The IHS has 51 hospitals, 72 health centers, and over 400 health stations providing services, primarily for reservation Indians. Provisions are being made to include urban Indians as well.

For some time, the Indian Health Service has recognized the need to involve the Indian in his own health needs. Because an Indian patient relates better to another Indian, and due to health personnel shortages, the Service has promoted and conducted health manpower training programs. Such programs have trained licensed practical nurses, dental assistants, health education aides, sanitary engineer aides, social worker aides, medical librarian aides, community health aides and, more recently, physician assistants. It is important to note that these programs have emphasized "aide and assistant-type" training programs.

When I visit the various Indian hospitals throughout the country, and ask to see the hospital administrator, I am introduced to a non-Indian. When I meet the medical officer in charge, I am introduced to a non-Indian. I ask, "How many people are employed in this hospital?" I am told, "Approximately 100." I ask, "How many are Indians?" I am told, "Between 70 and 75 percent." When I ask, "How many of these Indians are in management positions," I am told, "Perhaps three or four." It is clear that the management and professional positions, with few exceptions, are held by non-Indians.

Figures are deceiving. When one reads that over half of the 6,000 people employed by the IHS are of Indian descent, one is unaware that these 3,500 Indians are engaged in the lower categories of health careers.

Broadly defined, health manpower categories, or "Health Careers" are:

> Those health careers whose training program takes from several weeks up to, but not including, an Associate Degree, are referred to as the *Health Occupations* category.
>
> Those health careers that require an Associate, Bachelors, or Masters degree, are referred to as the *Allied Health Professions* category.
>
> Those whose training requires a Doctorate are in the *Health Professions* category, namely, medicine, osteopathy, dentistry, veterinary medicine, optometry, podiatry, pharmacy, and advanced degree nursing.

Invariably, Indians working in health programs belong to the Health Occupation category.

If we superimpose the Indian health manpower picture over these different Health Career categories, it begins to look like a triangle. Most Indians are in the Health Occupations, with few in the Allied Health Professions, and virtually none in the Health Professions. To illustrate this point, consider the following statistics.

There are approximately 700,000 registered nurses, 350,000 licensed practical nurses, and over 800,000 aides and orderlies in the country, totalling almost two million people who are considered part of the nursing profession. But only 400-450 have been identified as Indians. Only 38 Indians have been identified among the 320,000 physicians; two among the 25,000 veterinarians; two among the 18,000 optometrists; five among the 125,000 pharmacists. No Indians are to be found among either the 14,000 osteopaths or the 8,000 podiatrists. Of the 120,000 dentists, I am the only full-blooded Indian. To prove how little has been done to increase the number of Indians in the Health Professions, I have been the only identified Indian dentist for the past 16 years!

Not long ago I cited these statistics to people with influence and authority. They responded, "Dr. Blue Spruce, we want you to do something about these appalling figures."

On July 1, 1971, I was named Special Assistant to the Director of the Bureau of Health Manpower Education within the National Institutes of Health to direct a new federal program that will tackle this challenge. The program has two objectives.

THE immediate short range objective concerns those few Indian students presently enrolled in health profession schools. We must promote programs to insure that they complete their studies and graduate as Health Professionals. We must also reach the increasing number of undergraduate college Indians, motivate them, and attempt to direct them into health careers. Indians in the Allied Health Profession category should be given the opportunity to enroll in pre-professional courses so that they might one day attain an M.D., D.D.S., or D.V.M. degree. The many Indians in the Health Occupation category must also be reached. By their length of service and dedication, they are clearly an integral part of the health team. This group should have every opportunity to aspire to higher categories of health careers. And finally, early in their freshman year, Indian high school students should be made aware that a health career is attainable. We must design a program that will allow them to enter college and attain a health profession without having to face denial or damage to their self-esteem because they are not adequately prepared.

The long range objective of the program comes as the result of further findings, made evident by travel to universities across the country.

Health professional schools, willing to open their doors to Indians, are finding it difficult to tap into a pool of qualified and available Indian students.

What has caused this situation? The educational system to which the Indian has been subjected. In order to provide qualified Indian students for admission into universities and health profession schools, there must be an overhaul in the educational system provided for Indians.

It disturbs me to see Indian students treated as "special cases" because they are inadequately prepared in certain courses, especially the physical and life sciences, and mathematics. As a result, health profession schools have had to alter admission standards to allow the Indian to matriculate and then have provided special tutoring. They may even extend the length of time it takes for an Indian student to graduate. Students I talk to wish that their educational background had prepared them for science-oriented programs. If this problem is to be solved, a reorientation must take place early in the Indian students' education.

The long range goal of the program, therefore, is to reach the Indian child and examine the progression from adolescent, to student, to adult. Each environment that he or she will be exposed to must be evaluated.

The first environment is, of course, the family. An Indian mother or father may not value a "White man's" education. As a result, the child is not encouraged. The mother and father will have to be made aware that their son or daughter can attain a health profession and that one of the strongest influences they can provide is encouragement and moral support.

The second environment is the Indian reservation where relatives, friends, peers, and tribal leaders all exert great influence. Here again, encouragement is crucial. Instilling a sense of pride in pursuing and completing a professional education must become a responsibility of members of the reservation.

The next environment is primary education. Teachers, being the first to recognize a child's academic achievement and potential, must encourage the child to aspire to a health profession.

Cree

The same holds true in the secondary schools, but there are serious problems in this area — the high school counselors. An Indian student who seeks advice from his counselor is usually directed through the side doors to vocational and technical training. Historically, counselors direct Indians into this type of occupation. Why can't they open the front door and say, "You, as an Indian, can attain a health profession!"

When I told my counselor I wanted to be a dentist, he said dentistry is a profession for the sons of rich White men. He went on to say that a dental education was too expensive, would take too long, and be too difficult. Perhaps because I am an Indian with a great deal of pride, I accepted this challenge. In talks with Indian students, I find many have had similar experiences. Tragedy often occurs because the high school counselor fails to open all doors. Dramatic changes are needed at this level.

The next environment is the university. Here we have the vice chancellors, administrators, financial aid officers, counselors, and admission committees. They should be exerting a concerted effort to afford Indian students every opportunity and support to attain a health profession.

Most Indian children have never seen an Indian physician, dentist, nurse supervisor, health administrator, or pharmacist. Consequently, in their minds, health professions do not exist. The number of Indians who today are health professionals is small, but these people will have to take it upon themselves to serve as role models for Indian students.

Although my role model was a non-Indian dentist, he showed me individual attention, kindness, and took the time to show me his office. Overnight I wanted to become like this man. When I finished my predental work, I was approached by many people who attempted to direct me toward a career in medicine. But, my mind was made up; I had been motivated and my role model had left his impact.

The literature says that professionals who have attained a health professions career aspired to this goal between the ages of eight and ten. Motivation, early in a child's life, therefore, cannot be overemphasized. As the pool of Indian health professionals grows, hopefully their impact as role models will be felt by a broad spectrum of Indian children.

A new era dawns — an era of higher and broader destinies for the Indian people. Hopefully this program will open those doors that have been closed for so many years. But, to succeed, we need the cooperation of all people to insure that in 10-20 years, there will be many more Indian physicians, dentists, and nurses serving in their own hospitals, treating their own people, and improving the appalling health statistics that exist today. It is ironic that many people in this country, proud of technical and scientific accomplishments, are totally unaware of the serious basic educational and health needs of the first Americans.

There are three Native American students at Harvard Medical School. Kenneth W. Foster and Adoniram V. Bowen were kind enough to take time from their busy first year schedules to talk to the *Bulletin* staff. Ken and Don provided us with valuable assistance in the preparation of this special issue.

Interviews with:

Ken Foster...

He walks with long, purposeful strides, and though he appears to be lost in thought, Ken Foster, a Creek-Seminole Indian from Oklahoma, and a first year student at HMS, is ultimately aware of all that surrounds him. His gaze is direct, to the point. During our interview, he minced no words, entertained few niceties as he discussed his thoughts on the plight of the American Indian today. He has a winning smile, but it only appears when his listeners show that they understand what he is saying. He is contemplative, yet firm and direct in his responses to questions.

Ken is from Holdensville, Oklahoma, and he was educated in the public schools. He explained that he'd wanted to be a physician since high school. He was a good student, and went to East Central State College in Ada, Oklahoma. Through the efforts of David Potter, professor of neurobiology at HMS, and Iola Hayden and LaDonna Harris of Americans for Indian Opportunity, Ken applied and was accepted to HMS. Prior to entering the first year class, he spent a year at Harvard College to strengthen his science background. He explains that he wanted to come to Harvard Medical School both because of its reputation politically and academically. "Harvard will be a good tool, its graduates are respected and well known." He believes a degree from Harvard will assist him in his work within Indian communities.

Mr. Foster's goal is to affect necessary changes for better health care of the Indian. When discussing why Indian health care is in such dire need of overhaul, he mentioned the Public Health Service first. "The Public Health Service has not been as effective as it could be. The physicians are temporary, and though they are curious about the conditions of the Indian, few remain." Because there has been and still remains, a lack of understanding on the part of the PHS with regard to Indian problems, these problems remain unsolved.

Another aspect of the Indian health crisis is, specifically, the quality of life on reservations and Indian communities, and, in general, the treatment of Indians by the White man. This type of existence has taken its toll. "Health statistics indicate that Indians lead the list in major categories of both illness and death. Indian people have been forced to tolerate present living conditions," he said, "and we have no choice but to adapt. The dominant society and its government created the situation, but blames the result on the Indian people."

At this point in the interview, Ken mentioned an often overlooked aspect of the health care picture. More Indian physicians are needed, but ideally, because health problems vary from tribe to tribe, each should have a physician indigenous to it. "To be effective, you have to communicate, you have to understand what the problems are." Indians can better serve Indians.

If more Indians are to be trained as physicians, then the quality of Indian education must be significantly improved. Mr. Foster elaborated on some of the problems related to the educational system. "An Indian in the public school system is at an extreme disadvantage. His environment is so different from that of the White student that he easily falls behind. English is a second language for most reservation Indians, so the Indian child is forced to adapt to a totally alien situation. His identity is often negated, he is taught his history from the White man's point of view, and more often than not, finds school a painful experience."

If an Indian student falls behind in grade school, he most likely will continue the trend in high school. The withdrawal rate is high among

Doctor Mask: Iroquois

Indians in the public school system, because the framework within which a student must compete is foreign to him. If a student goes to college, another difficult process of adaptation is initiated.

On the other side of the coin, the Bureau of Indian Affairs (BIA) operates boarding schools for Indian students. But again, the disadvantages of this type of education are tremendous. The administration is so fraught with red tape that the quality of education is poor. Indian parents are loathe to send their children to BIA schools, but because overall family income is so low, it is often to their advantage to send a child to a BIA boarding school rather than provide for him at home.

The paradox is obvious: in the public school, Indian students are in an alien atmosphere and the dropout rate is alarmingly high; in the BIA boarding school, the quality of education is poor. Where is the solution?

In Ken's estimation, one answer is community control of Indian schools. He discusses a school in a small town in New Mexico where natives have joined together and taken control. Indian adults assist in teaching Indian children. The students learn within the context of their own environment and receive an education specifically suited to their needs. They maintain their identity and their culture while receiving an education equal to that in a White controlled school.

If the health and educational problems of the Indian people are to be solved, broad changes must take place. Where to begin? "The admissions committee has stated they would be glad to accept more Indian students if they could find qualified applicants," Ken said. "That's only half a step. With an educational system such as I've described, how can one lead to another?" He went on to define his concept of the Medical School's role in the training of Indian physicians.

"HMS considers itself a leader in the medical world. They pinpoint crisis areas. If Indian health and education isn't a crisis, I don't know what is."

The Medical School should take a leadership role in recruiting and training Indian physicians. But, Ken states, "people don't take the American Indian seriously; thus, significant steps in educating Indian physicians have not been taken."

It becomes a matter of priorities. If Indian health *were* a priority, the Medical School would begin to educate more Indian physicians. "They should be graduating a steady pool of Indian doctors each year," he asserted.

Ken evaluates the problems of the Indian people in terms of broad political issues. "This country divides people into classes — rich, poor, middle — and in a capitalistic country, these definitions usually stick. Once you have been thrust into a class structure, it is nearly impossible to get out. Class tends to perpetuate itself. It is all part of the same puzzle. All these components go together to make up the condition of the Indian people today: an inferior educational system, poor health conditions, prejudice, and poverty.

Ken felt that things were beginning to change, and the public was taking an interest in the Indian. He could not pinpoint the causes of the renewed interest, but believes that since the assassination of Martin Luther King, Jr., White Americans have begun to look deeper into the life of minority groups.

Americans relate to Indians in a peculiar way, according to Ken. On the one hand, there is a great deal of prejudice; on the other, it is not uncommon to hear the phrase, 'I'm part Indian. . . .' Indians have been romanticized, and at the same time, have been victims of the broader society.

The interview was drawing to a close, but the last question had to be asked. "What is the greatest problem facing the Indian today?" Ken Foster leaned back in his chair, shoulder length hair framing his face, and paused for what seemed like minutes.

"Representation," he said. Until recently, there have been few, if any, Indians on policy or decision making levels. There are a minimal number of Indian legislators in federal and state government. In cities where there are large Indian populations, local governments have only a sprinkling of Indian representatives.

Vine Deloria has written a book, *We Talk, You Listen.*

The problem is, no one has!

AND

DON BOWEN

NOT only is Don Bowen a Creek Indian, but he is from Seminole, Oklahoma, a part of the country most easterners fly over on the way to California. The twang of his voice can easily be mistaken for a southern drawl, and it is obvious he is aware that he personifies all the mistaken notions people have of Indians, midwestern rural dwellers, and medical students. Bowen is a study in the inaccurate stereotype. When one thinks of Indians, especially if one is from the East, one sees first, John Wayne. After this, one sees feathers, war paint, leather breeches, and long, flowing black hair.

Don Bowen is definitely not John Wayne. His hair is clipped in the current student fashion, his slacks are the familiar dungarees, and he carries a book bag that fits into every picture of "typical student accessories." It is only his accent that gives him away as being other than the more commonly seen Bostonian, New Yorker, or Philadelphian. It would be easy to mistake him for a Chicano, Puerto Rican, or Oriental, which, he reminds us, is precisely what often happens.

During our interview, it became apparent that here was where the stereotype ended. It leaves no gap, for as Don Bowen speaks, it is easy

to see that he is a man committed to his people, and is bound to make his medical school career benefit them in whatever way he can. To clarify the fuzzy picture many people have of the midwest and the Indian population that resides there, he describes his tribe and the area where he grew up.

Prior to the mid-1800's, five Indian Nations lived in the southern part of the United States. During and immediately following the Civil War, they were driven out by White men. The Creek Nation settled in Oklahoma, where they lived on Indian Territory, and conducted their business with the federal government in much the same way a foreign country would.

It is difficult to think of the American Indians as immigrants in their own country, but Don explained that this is indeed how they felt, as they were pushed from their original homes to the plains states. In 1907 Oklahoma was made a state; the Land Allotment Act wiped out all Indian Territory. The tribes, left with no land, and scattered throughout the state, were caught in a vast economic and cultural gap. The nature of the tribe and its government were drastically altered, but Don quickly reminds us that Indians were still Indians, though their life styles were severely curtailed. There are no reservations in Oklahoma today; the Indian people have no land base, no focal point for their existence.

In the mid-sixties, Indian nationalism began to develop. In response to a question concerning the rise of self-determination, Don explains that the Indian people, sharing the same social and economic problems of other minority groups in the nation, had reached a point where organizations *had* to grow and develop to meet those needs.

Mr. Bowen traces his new attitudes back to when he entered college. There, he met other Indian students, with whom he shared a heritage. He watched the growth of Indian organizations and was sympathetic to, and understanding of, their goals and stands on issues he felt were important to all Indian people.

Don laughed as he recalled his high school career. With one exception, all his teachers pointed him toward trade school. He remembers being lonely and confused when he realized he was one of the few students not receiving college counselling. He smiles and notes that if anyone had told him then that he was going on to college, let alone medical school, he would have thought they were crazy. It was through the inspiration of his family, and the spurring on by his history instructor, who cared enough to ask, "What college are you going to?" that he applied to Oklahoma University after he'd worked and saved some money. Sitting back in his chair, fingering the book he held in his hand, he mentioned sardonically that he paid his tuition and expenses in installments, not expecting to stay beyond the first semester.

But stay he did, and after graduation, decided to go to graduate school. Leaning forward, he explains that he deliberated between law and medicine, because he felt that it would be in one of these two professions that he could really affect changes in his community. With skills in law or medicine, he could return to Seminole, Oklahoma and help his people.

The decision to enter medical school was a sudden one for Don. A friend was applying to Harvard Law School, and it was through him that he learned Harvard was recruiting Indian students for the Medical School. He turned to the Oklahomans for Indian Opportunity to clarify that knowledge, and when they confirmed it, he applied to HMS.

"We need more Indian physicians," he asserted, and discussed his MCAT examinations, sounding at once incredulous and determined to end the pattern that was illustrated in that room. "There were hundreds of students," he said, "but there were no other Indians and only two Blacks. I never felt so lonely. So many people are missing out on the opportunity to train Indian and Black physicians, and it is so obvious that more of us are needed." The health problems of the Indians and other minority groups are grave, and the people best suited to begin solving those problems are professionals from those populations.

When asked specifically about these health problems, Don Bowen responded quickly. Indians have a high rate of cardiovascular disease, a high death rate due to influenza, and a high infant mortality rate. The statistics concerning infant mortality are higher among Indians than any other population in Oklahoma. But, he reiterated, the social nature of these problems are similar to those faced by all minority groups. The only difference between the Indian population and other minorities, he pointed out, is that the Public Health Service still provides free care to the Indians, in their Indian hospitals and health clinics. But, he added, clinics are few and far between. Rural Indians must travel for miles, sometimes a full day, before they reach the hospital or clinic. Waiting periods are long; the service is fragmented. You rarely see the same doctor twice, medical records can't be kept up to date, and there is virtually no preventive care. We have little access to private physicians, he explained. Who can afford a private

Indians must rebuild the identity the larger society has tried to destroy.

physician if their yearly income is less than $3,000, which is the average for most Indian families? There is a grave psychological inaccessibility to hospitals, especially in the urban areas. The employment situation faced by the Indian is so serious that taking a day off to see a doctor often means loss of a day's pay. One way to deal with this is to have more doctors; the more effective way is to have more Indian doctors. This involves recruitment and training which must be designed to reach the Indian student, and tailored to meet his particular needs.

In discussing recruitment, Mr. Bowen repeated that Indian physicians are best able to meet the needs of the Indian people, but unless recruiting programs are total efforts that begin in high schools, the number of Indian physicians needed will never be trained. The most crucial aspect of recruitment is to make Indian students aware that medical school is accessible to them; if they concentrate on their studies, they can become physicians. Medical schools, colleges, and high schools must work together to create recruiting and educational programs designed to prepare Indian students to enter medical careers. The crux of the problem, he explained, is to begin as early as possible, and continue working throughout college.

He pauses, and you can see he is searching for the appropriate words to convey the differences between a White physician and an Indian physician in treating Indian patients. "I know that when an 80-year-old woman comes to me for help," he said, "she is not going to like me examining her. But because I realize that old Indian people do not like to be touched, I can treat her with the respect and dignity due a woman of her age." Older people are much respected in an Indian community. A White physician, unfamiliar with this culture, can't understand this; only an Indian physician can. Therefore, the training and recruiting of more Indian doctors, although difficult, becomes even more important if the health needs of the American Indian are to be met.

In response to a question about the most pressing problems that affect Indians today, Don responded with conviction: identity. It is essential if the Indian people are to regain their pride and dignity. But, he said, it is something we must do ourselves. No one can hand us an identity and say, "Here, it's yours. We must shape it for ourselves. Our history has been badly misrepresented by your history books and popular entertainment. There has been a policy of extermination directed toward the American Indian, and though it was never written down, it certainly was carried out. We are threatened with extinction, but because of our dedication to survive and thrive, this policy will never be totally carried out. It is the business of the Indian to rebuild the identity that the larger society has attempted to destroy. Our government has been rendered almost ineffective; we have been scattered, our land stolen from us, our tribal structure mutilated, but we will maintain ourselves and rebuild. Nothing short of genocide will prevent this."

This rebuilding and correcting has begun. Books are being written by American Indians that trace history from our point of view. Some White authors have written on this subject recently, and taken the Indian standpoint, but it is important that the Indian write his own history. Indians are beginning to organize and deal with the problems that affect us as a people. "As a physician," he said, "I'll be able to help in this struggle. My skills will be returned to the Indian people."

In closing, Don Bowen retraced his steps and pointed out that the Indians we know are primarily the plains Indians. He emphasized that there were Indian tribes in the South and East who were assulted long before the plains tribes. Their histories must be written. He was emphatic, and ended the interview with a quote from Winston Churchill. He smiled, leaned back in his chair, and said: "Churchill said that history would deal kindly with the Americans in the Second War because he would write it." Don Bowen has pledged that, for his people, he will do the same.

Additional Reading List

Zuni

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Night Shoot: Sioux

Mimbres

book reviews

Voices from the Drug Culture is written by a third year student at Harvard Medical School. Because of the timeliness of Mr. Pope's book, the *Bulletin* asked two people to review it: Dana L. Farnsworth '33, Henry K. Oliver Professor of Hygiene, Emeritus, and former director of the University Health Services; and Jonathan Lieff '72.

Voices from the Drug Culture by Harrison Pope, Jr. '73. 147 pages. Cambridge, Massachusetts: The Sanctuary, 1971. $2.50.

What to do about the increasing numbers of people, especially the young, who are using drugs for non-medicinal purposes is one of the major unsolved issues of our times. Solutions by the hundreds have been advanced, ranging through every variety of the standard repertoire of professional psychotherapies to group activities using every kind of procedure, from gentle suggestion or persuasion by participants on one another to brow-beating. "Hotlines" for those who are troubled about their use of drugs (or any other problem) have been established in many thousands of communities. Special-action programs, coordinating councils, commissions, research units, rehabilitation centers, and a variety of other investigative and evaluative bodies are hard at work seeking the elusive solutions. The books and articles, surveys and catalogs of treatment centers, and treatises designed to prove the authors' pre-formed theses are getting too numerous for all but a few to keep up with.

This book is different. A thin paperback, a revision of an undergraduate honors thesis, it furnishes "data . . . obtained in a cloudy intermediate zone between the imposing precision of the laboratory study and the clinical thoroughness of the individual case history." Pope became interested in the drug subculture in 1967 and visited Haight-Ashbury in San Francisco. Wishing to learn more about drug use, he asked Erik Erikson, his tutor, for advice. The advice was not to try to find answers to specific questions, but "just go out and live there for awhile and see what feelings come to you, and I think you will find many things to write about."

Since then he has studied young drug users in Boston, the Lower East Side in New York, visited high schools in the Midwest and West, and has had many visits and interviews with friends made during his studies.

Why do most young people take drugs? For fun. He found little evidence that most of them use drugs either to fill a need or to escape from something. Many of them experience both boredom and a feeling that their parents lead boring lives. Their dissatisfaction begins with a loss of interest in the life-style they have observed around them, and gradually they become alienated in the sense that Keniston has described. Drugs become a potentially exciting and meaningful release from the dullness of uncommitment.

Lest enthusiasm for all the author's findings and interpretations be too obvious, and thus misleading, I would disagree with his statement that alcohol, nicotine, and caffeine are "rarely used for sheer enjoyment alone, but to cope with environmental stresses." But I must remember that his world and mine are quite different.

His explanation of the role played by marijuana in developing hostility to the establishment and disrespect for law, as well as receptivity to taking more harmful drugs, is clear; and his analysis of the complications or residual effects of LSD, the opiates, the amphetamines, and cocaine is disarmingly simple but devastatingly convincing. Without the slightest tendency to moralize, and in language devoid of jargon, he gets across points that professional drug educators all too often strive for in vain.

This book about the drug culture is unlike any other I have read. Its author knows his subjects well, has no predetermined point of view to prove or defend, and manages to give his readers a picture of life in the drug culture so vivid as to be both fascinating and terrifying.

Physicians, medical students, and anyone contemplating using drugs without supervision should read it. And parents, too.

DANA L. FARNSWORTH '33

Voices from the Drug Culture by Harrison Pope, Jr. '73. 147 pages. Cambridge, Massachusetts: The Sanctuary, 1971. $2.50.

No one doubts that the "drug problem" is a real medical issue these days, but, in spite of profuse verbiage, few professionals have any true perspective on the essence of the problem or of the culture surrounding it. Several years ago, a number of cultural historians claimed that the popular use of mind-altering drugs was decreasing. Now it is clear that this is not true. In the last few years, many young people in our society have begun to use a variety of psychotropic chemicals as routinely as older members of society use alcohol, caffeine, or nicotine. If we characterize this group, now comprised of millions of young people, primarily by their use of relatively unfamiliar mind-altering agents, then we have what is called the "drug culture."

Scientific critics of Harrison Pope, Jr.'s book *Voices from the Drug Culture* may protest that his study was uncontrolled, his questioning open-ended, his conclusions psychiatrically oversimplified. Critics from the drug culture may consider him a spy. But those who have observed the changing drug culture over the last five to ten years will know that much of what he has observed is accurate and widely applicable. His work fills a need not met by psychiatric research into patient reactions to "drug use." Previous works have rarely helped us understand the incredible multiple manifestations of drug usage in high schools, colleges, or in the "street scene." In a graphic, first-hand manner, Pope describes many of the complex factors involved in the use of mind-altering chemicals by youth, bringing to the material the flavor of reality.

Why are young people taking these substances in such great abundance? Pope suggests three basic reasons; fun, friends, and fulfillment. Fun is an overused, but little understood, word describing a wide range of experience from a soda to an ecstatic sexual embrace. By ignoring "fun" we miss an essential aspect of youthful drug use. "For most of the thousands of drug experiences that I have closely observed, users are having fun; to deny this is to forfeit any chance of understanding drug use," says Pope. It is clear to many children that the elders who dismiss fun, and accept only pathological reasons for drug use, are simply not capable of understanding the real factors involved.

"Friends" as a reason for drug use can be understood at the level of social amenities: "Have a drink, friend! Have a joint, friend!"

Fulfillment is a bit harder to understand, for it focuses on changing attitudes towards what makes a whole or successful man. That inner experience plays a large role in the new formulation of a whole man is clear. It should come as no surprise that drugs affecting the inner experience are used by young people seeking a fuller or different sense of themselves and their potentials. In a culture that values aggression, competition, and productivity, an individual's search for meaning may well involve an escape from a mass-production lifestyle into the drug culture.

Like everything, the drug culture changes. In places where hippies first proclaimed, "acid, flowers, and love," there followed a change of personnel and drugs. The flower children moved on, taking their marijuana and psychedelics with them. They were replaced by a harsher element consisting of barbiturate and opiate users. The term, "drug use," therefore, is semantically and politically confusing because it refers to vastly different groups whose only common denominator is their illegal use of drugs.

Drugs, however, are merely the symbols of change — symbols of an attitude or a state of mind. Just as coffee connotes efficiency and hard work, so different drugs, in the battery of chemicals used by today's youth, represent and simulate desired attitudes or states of mind. With each drug, there is a mystique of cultural associations that interact with pharmacological effects. The new drugs, like the drugs of the elders, are used in innumerable ways for social intercourse. This use is only remotely related to pharmacological effect.

This book illustrates many of these observations using interviews with numerous young drug users. It sheds light for those who want light on drug use. It will be helpful both for those who are critical of, or sympathetic to, young drug users. This is, perhaps, the book's greatest strength.

JONATHAN LIEFF '72

Alumni, Organize!

An Open Letter to the Alumni:

Everyone is seeking a role in running the Harvard Medical School. Student power, community power, and faculty power have begun to have their voices heard. Each in its own way is already influencing the future course of the School. The fourth constituency, the Alumni of the Harvard Medical School, has been most generous in its financial support through the "Program for Harvard Medicine" and by annual giving to the Alumni Fund. But, as far as having an input into the affairs of the Medical School, the Alumni are among the silent majority.

In an effort to inform the Alumni about the state of the School, and in order to have them become more actively involved, we have begun to make visits to various regions of the country, to explain the plans for future activities of the Harvard Medical Alumni Association, and to elicit comments and recommendations. During early December of 1971, Joseph Donnelly, director of development, and I met with some of the Alumni in New Orleans, Houston, and Dallas.

In New Orleans, we had dinner and a fine discussion with Betty and Tom Duncan '42; Lorna and Charlie Dunlap '42; Abba Kastin '60; Dell and Mike Connell '61; Barbara and Ted Hyman '55; Alece and Sam Karlin '32; and Joyce and Vann Spruiell '55.

At the gathering in Houston, we were pleased to see: Jim McMurrey '47; Marc Moldawer '50; Bill Baird '42; Stan Crawford '46; Joe Merrill '48; Bill Owen '49; and Cheves Smythe '47.

In Dallas, Jesse Thompson '43A arranged a dinner at the Dallas Petroleum Club that was attended by Harry Spence '30; Gordon Hosford '57; Billy Potts '26; Bill Altman '39; Al Hendler '49; Hal Moore '35; Murray Schonfeld '51; Hal Urschel '55; Marion Greve '45; and Bill Kraus '52. Joining us from Ft. Worth were Stan Marietta '41; John Harter '53; and Robb Rutledge '49.

These initial meetings have pointed out several interesting and surprising facts. Those attending the gatherings were pleasantly surprised to become acquainted, for the first time, with fellow Alumni of their area. Enthusiasm for the School was high and all were pleased that someone from Shattuck St. would make the effort to come and see them. They were even happier to know that active steps are being taken to organize regional Harvard Medical Alumni groups to serve as a forum for regular visits by faculty, students, and administration from the School. The Alumni were also informed that they would become increasingly involved in counselling and interviewing applicants for the School from their areas, and would have a voice in determining the selection of such applicants. It was evident that many areas of the U.S. are eager to have HMS students come for a clinical clerkship and would like to have graduates consider internship or residency in their locale.

Alumni expressed a desire for broader communication from HMS. They look forward to the *Alumni Bulletin* presenting much more news about daily activities and programs at HMS, and would welcome opportunities to express their own opinions about the School's plans and policies. They also would favor an effort by HMS to develop continuing education programs expressly for Alumni either in Boston or on a regional basis.

This feedback from Alumni is just the beginning of a response from the fourth constituency. Questionnaires for the reports of reuning classes will hopefully elicit further information about Alumni attitudes and expectations. Finally, I can assure you that letters of criticism, recommendation, or advice will be most heartily welcomed. Please let me hear from you.

PERRY J. CULVER '41
Director of Alumni Relations